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MEDICARE APPEALS PROVISIONS

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ORIGINAL

HEARING

BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
NINETY-NINTH CONGRESS
FIRST SESSION
ON
S. 1158

NOVEMBER 1, 1985

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MEDICARE APPEALS PROVISIONS

FRIDAY, NOVEMBER 1, 1985

U.S. Senate,
Committee on Finance,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger and Grassley.

[The press release announcing the hearing and a background paper on Medicare appeals follow:]

Subcommittee on Health Reschedules Hearing on Medicare Appeals Bill

The Senate Committee on Finance's Subcommittee on Health has rescheduled its hearing on S. 1551 and the beneficiary and provider appeals provisions under Part A and Part B of the Medicare program, Committee Chairman Bob Packwood (R-Oregon) announced today.

The Health Subcommittee hearing has been reset to begin at 9:30 a.m., Friday, November 1, 1985, in Room SD-215 of the Dirksen Senate Office Building in Washington.

The hearing had been set for October 28.

Senator Packwood said the Subcommittee will review the Medicare appeals provisions as part of the panel's oversight responsibilities.

Senator Packwood said Senator David Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the November 1 hearing.

In conjunction with its review of the appeals provision under both parts of the Medicare program, the Subcommittee will examine S. 1551, the Medicare Appeals Act of 1985.

S. 1551 was introduced July 16 by Senator Durenberger with Senators John Heinz (R-Pennsylvania) and John H. Chafee (R-Rhode Island) as original co-sponsors.

Written statements must be delivered to the Committee no later than 5 p.m., Friday, October 25, 1985.

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MEDICARE APPEALS

Background Paper

Prepared for the Use of the Members of
The Committee on Finance

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Education and Public Welfare Division
October 1985

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I. OVERVIEW

The Medicare program provides specific reconsideration and appeal rights for beneficiaries, providers, and practitioners who are dissatisfied with determinations of program benefit payment amounts.

Under the Hospital Insurance (Part A) program, the intermediary 1/ makes an initial determination on a benefits claim, either approving it or denying it in whole or in part. The beneficiary may request a reconsideration determination which is made by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS). If a beneficiary appeals an initial determination, the provider 2/ is made a party to the reconsideration process. A provider may initiate a request for reconsideration only if the liability rests with the provider or the beneficiary and the beneficiary has indicated in writing that he or she does not wish to appeal. If, however, Medicare has made payment for all noncovered items and services under the "waiver of liability" provision 3/, the provider has no right to appeal nor is it made a party to the determination if the beneficiary appeals.

1/ An intermediary is a national, State, or other public or private entity which has entered into an agreement with the Secretary to process Medicare Part A claims from providers.

2/ The term provider generally refers to a hospital, skilled nursing facility, or home health agency.

3/ Payment may be made under a "waiver of liability" to a provider of services for certain uncovered or medically unnecessary services furnished to an individual if the provider could not have known that payment would be disallowed for such items and services. Providers are presumed to have acted in good faith, and therefore receive payment for services later found uncovered or unnecessary, if their total denial rate on Medicare claims is below a certain prescribed level.

If the amount in controversy under Part A is over $100, the reconsideration determination may be appealed to an administrative law judge in the Social Security Administration (SSA). If the amount in controversy is over $1,000, the final determination may be appealed to the courts.

Under the Supplementary Medical Insurance (Part B) program, the carrier 4/ makes the initial determination on a benefits claim. A beneficiary may request a review determination from the carrier. A physician or supplier who has accepted assignment 5/ on a claim may also request a review. If the amount in question is $100 or more the claimant may request a "fair hearing" by the carrier. The law does not provide for any administrative appeal to or judicial review of the fair hearing decision.

Over the past decade, the structure of the Medicare appeals process has been the object of heightened scrutiny by a coalition of beneficiary, provider and supplier organizations. A primary concern has been that beneficiaries have no avenue of appeal for Part B claims beyond the Medicare carrier. The original design of the Part B appeals process reflected both the expectation that Part B claims would be relatively small compared to Part A claims and the perceived need to prevent overburdening of the courts. However, a number of changes have occurred in Part B since enactment of the program. These include the increasing focus on outpatient care which is financed primarily under Part B and the significant increase in requests for carrier reviews and carrier hearings.

4/ A carrier is a private insurer, group health plan, or voluntary medical insurance plan which has entered into an agreement to process claims under Part B.

5/ By accepting assignment the physician or supplier agrees to accept Medicare's payment determination as payment in full except for the required beneficiary cost-sharing amounts.

The absence of appeals beyond the carrier level has also raised a number of due process questions which have been addressed by the courts. The Supreme Court has ruled that the appointment of hearing officers by Part B carriers does not violate due process considerations. Questions relating to due process for claims with less than $100 in controversy were addressed in the class action suit filed by the Gray Panthers in 1977 (Gray Panthers v. Califano, 466 F. Supp. 1317 (D.C. 1979)). In 1980, when the case reached the Appeals Court, it ruled that the existing explanation of benefits forms used by carriers did not provide an understandable explanation of why benefits were being denied. The court further stated that due process principles were violated because by regulation, oral hearings were precluded in all cases involving less than $100. In 1982, when the case reached the Appeals Court a second time, the court stated that oral hearings should be required only in a minority of cases such as where the claimant's credibility or veracity were in question. It concluded that the revised explanation of benefits form developed by HHS together with current written review procedure and a toll-free telephone system should be adequate in most instances. The case was remanded to the District Court. A stipulation was filed on September 5, 1985 in the District Court which states that HHS and the Gray Panthers have reached a mutually satisfactory agreement for resolving the substance of the due process issues related to Part B.

For a number of years, the changing nature of the Part B program coupled with the ongoing examination of due process issues has led a number of groups to recommend an expansion of the Part B appeals process. The pressure for change has increased over the years as Part B claims, and associated beneficiary liability on such claims, have risen significantly.

Recommendations for change in the Medicare appeals process have not been restricted to those relating to Part B benefit claims. A coalition of representatives of provider and beneficiary groups have recommended other modifications including those related to Part A appeals and provider appeals.

II. MEDICARE APPEALS PROCEDURES

A. Part A Appeals of Benefit Payment Amounts

1. Initial Determination (Intermediary)

The provider of services (e.g., a hospital) requests payment under Medicare by submitting a bill to an intermediary. The intermediary then makes an "initial determination," either approving, denying, or partially denying the claim. The beneficiary is notified regardless of the determination either by HCFA, the intermediary, or both. If the claim is paid, HCFA sends a Medicare Benefit Notice to the beneficiary informing him of his benefit utilization and deductible status. If the claim is denied the intermediary sends a disallowance letter to the beneficiary. If a claim contains both allowed and denied items, both notices are sent.

The provider must also be notified in writing of the intermediary's determination if the services furnished to the beneficiary are not covered under Part A because they are: 1) not reasonable and necessary or constitute custodial care; and 2) the intermediary makes a finding that either the beneficiary or the provider knew or could reasonably have been expected to know that the items or services were not covered.

All of the notices must explain the reasons for the determination and must inform the beneficiary and the provider of their right to have the determination reconsidered if they are not satisfied.

2. Reconsideration Determination (HCFA)

If the beneficiary is dissatisfied with the initial determination's denial or with the benefit payment amounts, he or she may file a written request for a reconsideration of the intermediary's initial determination. The beneficiary may ask for reconsideration regardless of the amount in controversy.

If a beneficiary appeals an initial determination, the provider is made a party to the reconsideration process. A provider may initiate a request for reconsideration only if the liability rests with the provider or the beneficiary and the beneficiary has indicated in writing that he or she does not wish to appeal. If, however, Medicare has made payment for all noncovered items and services under the "waiver of liability" provision, the provider has no right to appeal nor is it made a party to the determination if the beneficiary appeals.

A request for reconsideration should be filed within 60 days of receipt of the notice of initial determination. (The date of receipt of the notice is presumed to be five days after the date of the notice.) The HCFA may extend the time for filing for good cause (such as circumstances beyond an individuals control, including mental or physical impairment, or incorrect or incomplete information furnished by official sources).

When reconsidering the initial determination, HCFA reviews the evidence and findings upon which that determination was based and may consider any newly-obtained evidence. The HCFA then renders a reconsideration determination, which may affirm or revise the initial determination. The HCFA must inform all affected parties, in writing, of the reconsideration determination. The notice must explain the reasons for the determination and must advise the parties of their right to a hearing before an administrative law judge.

3. Hearing (SSA Administrative Law Judge (ALJ))

If the amount in controversy is $100 or more and the claimant is dissatisfied with the reconsideration determination, the claimant may appeal the reconsideration determination to an ALJ of the SSA Office of Hearings and Appeals. A request for a hearing must be filed within 60 days of the receipt of the notice of the reconsideration determination except when the time has been extended for good cause. The ALJ considers the HCFA case file and evidence presented by the claimant and the claimant's witnesses. The ALJ renders the decision, notifies the claimant, and places a copy of the decision in the appropriate case file.

4. Appeals Council Review (SSA)

A claimant dissatisfied with the ALJ's decision may ask the Appeals Council of the Social Security Administration's Office of Hearings and Appeals to review the decision. The Appeals Council may either grant or deny this request. The Appeals Council may also decide to review an ALJ decision on its own.

When the Appeals Council completes its review or when the 60-day limit to appeal expires, the Office of Hearings and Appeals forwards the case file to the HCFA regional office, which then instructs the intermediary as to what actions to take.

5. Judicial Review (Federal District Court)

The claimant may institute action in a Federal District Court if the amount in controversy is $1,000 or more and the claimant is dissatisfied with the Appeals Council's decision (or the ALJ's decision, in cases where the request for appeal has been denied).

B. Part B Appeals of Benefit Payment Amounts

1. Initial Determination (Carrier)

When a request for Part B benefits is submitted, the carrier 6/ makes an initial determination as to the amount of benefits.

The carrier completes an Explanation of Medicare Benefits form (known as the EOMB) to notify the beneficiary of action taken on the payment request and his or her appeal rights. Only in cases where the physician or supplier accepts assignment, is notice also sent to the physician or supplier.

2. Review Determination (Carrier)

The beneficiary may request a review determination if he or she is dissatisfied with the initial denial or with the benefit payment amounts. The review determination may be requested by the beneficiary in his or her own right or through an attorney or other authorized representative appointed by the beneficiary. A physician or supplier who has accepted assignment on a claim is also entitled to a review. The written request for a review by the carrier must be filed within six months of the initial determination.

The carrier reviews the case based on written evidence without an appearance by the claimant. After the review, a review determination letter is mailed to all involved parties to notify them of the reasons for the review determination and informs the claimant of his or her right to request a "fair hearing" if the claimant is dissatisfied and the amount in controversy is $100 or more.

6/ In the case of Part B services rendered by providers (e.g., hospital, skilled nursing facility, or home health agency) this function is performed by intermediaries.

3. Fair Hearing (Carrier Hearing Officer)

If the amount in controversy is $100 or more and the claimant is dissatisfied with the carrier's review determination or if the request for payment is not being acted upon with reasonable promptness (i.e., 60 days), the claimant may request a "fair hearing" from a hearing officer appointed by the carrier. The request must be filed within six months of the date of the notice of review determination.

The claimant may appear in person at the hearing and may choose to be represented by legal counsel or any other qualified individual. The claimant and representatives may offer oral and written evidence, examine and reply to the carrier's evidence, and present and examine witnesses. The claimant may waive these hearing rights and withdraw a request for hearing. The claimant may also choose to have the hearing conducted by telephone. If all parties agree, the hearing officer may decide the case on the evidence at hand without a formal hearing.

The hearing officer, appointed by the carrier, must be competent and impartial. The officer must decide the case in compliance with Medicare law, regulations, and other HHS issuances. The officer has no jurisdiction over issues for which SSA or the Secretary is responsible (e.g., entitlement, conditions for participation, or coverage of services) or which relate to Part A benefits. Each involved party is notified of the fair hearing decision by mail.

Unlike the provisions for Part A appeals, the Social Security Act does not provide for any administrative appeal to or judicial review of the Part B fair hearing decision.

C. Other Appeals

The law provides for appeals in addition to those related to benefit amounts on an individual claim. These include entitlement appeals, provider reimbursement appeals, and appeals of initial denial determinations made by peer review organizations.

1. Entitlement Appeals

If the intermediary or carrier decides the disputed claim involves questions of entitlement to benefits or enrollment under Part A or Part B and if the beneficiary is dissatisfied with the initial SSA determination, he or she may appeal the disputed claim to an ALJ, then to the Appeals Council, and finally to a court for judicial review of the Secretary's decision--regardless of the amount of benefits in controversy.

2. Provider Reimbursement Appeals

The intermediary is required to notify the provider of the amount of program reimbursement within 12 months of receiving the provider's cost report. If the provider is dissatisfied with the amount on the notice, and the amount in controversy is at least $1,000 but less than $10,000, the provider may request (within 180 days of the intermediary's notice) a hearing before a hearing officer or panel of hearing officers chosen by the intermediary. Hearing officer decisions are subject to review by HCFA either on a motion initiated by HCFA or at the request of the provider. The law provides no avenue for judicial appeals of the hearing officer's or HCFA's decisions.

If the amount in controversy is $10,000 or more, a provider may request a hearing before the Provider Reimbursement Review Board (PRRB)--a five-member board appointed by the Secretary. Groups of providers may request a PRRB hearing if the amounts in controversy aggregate to $50,000 or more but only if the matters in controversy involve a common issue of fact or interpretation of law or regulation. Providers must appeal as a group if they are under common ownership or control and if they are appealing a common issue. The Secretary on his or her own motion may elect to review the PRRB's decision and may reverse, affirm, or modify such decision within 60 days. The provider is entitled to judicial review of any such action by the Secretary and any final PRRB decision.

For hospitals under the prospective payment system, administrative and judicial review is prohibited for disputes arising over the prospective payment rate level, the establishment of diagnosis-related groups (DRG's) and the appropriate weighting of such groups.

3. Appeals of PRO Initial Denial Determinations

Utilization and Quality Control Peer Review Organizations (PROs) have the authority to make initial determinations involving reasonableness of services, medical necessity of services, or appropriateness of the inpatient setting.

A beneficiary, provider, or practitioner dissatisfied with a PRO initial denial determination is entitled to reconsideration by the PRO that made the initial denial determination. The reconsideration must generally be completed within 30 days of the request. However, when the initial denial determination is made during preadmission review or if the patient is still in the hospital, the PRO must make such determinations and send written notice within three days.

If the amount in question is $200 or more and the beneficiary (but not a provider or practitioner) is dissatisfied with the reconsidered determination, he or she may obtain a hearing by an ALJ. As in the case of Part A appeals, under certain circumstances the SSA Appeals Council will review the ALJ hearing decisions.

If the amount in question is $2,000 or more and the beneficiary is dissatisfied with the Appeals Council decision (or the ALJ decision if a request for review by the Appeals Council was denied), the beneficiary may obtain judicial review of the previous decision provided the amount in question is $2,000 or more. A reconsideration or hearing that is provided under these provisions fulfills the requirements of any other review, hearing, or appeal to which a beneficiary may be entitled under Medicare.

Under certain circumstances, these appeal procedures also apply to inpatient days deemed no longer medically necessary or custodial in nature. If a hospital determines that a beneficiary no longer requires inpatient care, and the attending physician concurs in writing with this determination, the hospital is permitted to charge the beneficiary for continued hospital care. If the hospital is unable to obtain the physician's concurrence, it may obtain an immediate review by the PRO. Concurrence by the PRO in the hospital's determination serves in lieu of the physician's agreement. The hospital must notify the beneficiary in writing: 1) of the determination that the beneficiary no longer requires inpatient care; 2) that customary charges will be made beyond the second day following the notification date; and 3) that the PRO will make a formal determination on the validity of the hospital's finding if the beneficiary remains in the hospital after he or she is liable for charges. This PRO determination is appealable by the hospital, attending physician, or beneficiary under the appeals procedures applicable to PRO determinations affecting Part A payments. [These provisions are contained in 42 C.F.R. 412.42.]

III. CARRIER APPEALS DATA 7/

Carriers received 3.2 million requests for Part B review determinations in calendar year 1984. Of the 3 million cases processed to completion during the period, 1.3 million (43 percent) affirmed the original determination and 1.7 million (57 percent) reversed the prior determination. (The remaining 0.3 percent of the cases were dismissed or withdrawn.) The average dollar amount per reversal was $118 for a total of $205 million.

Carriers received 30,032 requests for fair hearings in 1984. Of the total 28,529 hearing requests processed to completion, 7,746 (27 percent) affirmed the prior determination, 13,145 (46 percent) reversed the prior determination, and 9,979 (27 percent) were dismissed or withdrawn. For those cases on which determinations were made, 63 percent were reversed in favor of the beneficiary (or supplier of services). The average dollar amount of the reversal was $439 for a total of $5.8 million.

An examination of a claim may be conducted subsequent to a formal adjudication at any level either through submission of additional information by the claimant or by the carrier's own activity. In calendar year 1984, 816,887 revisions were made to prior determinations. Of the total revisions, 234,100 (29 percent) were unfavorable to the claimant, and 582,787 (71 percent) were favorable to the claimant. The dollar amount of revisions favorable to the claimant were $57.2 million or $98 per claim.

7/ Data in this section is from the Carrier Appeals Reports, October-December 1984 and January-March 1981 issued by the Health Care Financing Administration, April 1985 and May 1981.

Several trends can be observed in the carrier appeals data. Between calendar year 1980 and 1984, there was a 45 percent increase in review determination requests received by the carriers. Between 1983 and 1984, there was a 31 percent increase. The percentage of review cases affirmed compared to the percentage reversed remained approximately the same over the 1980-1984 period.

Requests for fair hearings increased 15 percent from 1980 to 1984. There was a slight increase in the percentage of cases reversed (from 60 percent to 63 percent on those which action was taken). The dollar amount awarded to claimants in revisions climbed from $2.5 million in 1980 to a high of $6.8 million recorded in 1983. In 1984, the total declined to $5.8 million. The average amount per reversal went from $229 in 1980 to a high of $515 in 1983 and declined to $439 in 1984.

In 1984, 20,682 fair hearings were held. Of these, 11,604 were formal hearings where the beneficiary (and/or counsel or other representative) or the physician/supplier appeared in person at the hearing. At the remaining 9,078 hearings, the beneficiary or physician/supplier waived the right to appear before the hearing officer; in these cases, the hearing officer made a decision on the record. Close to two-thirds (64.9 percent) of the hearings involved issues pertaining to reasonable charge determinations, 15.7 percent involved medical necessity issues, 15.2 percent involved coverage issues, and 4 percent concerned other questions. The average amount in controversy was $1,043 ($1,245 in the case of formal hearings, $783 for hearings on the record). The average elapsed time from request to decision was 94 days (104 days in the case of formal hearings, 79 days for hearings on the record).

IV. ISSUES

A. Adequacy of Part B Appeals Process

The current structure of the Medicare appeals process has raised a number of concerns on the part of beneficiary and provider groups. Primary among them is the fact that beneficiaries have no avenue of appeal beyond the Medicare carrier with respect to Part B claims. By comparison, beneficiaries may appeal Part A claims to the ALJ when the amount in controversy is over $100. They are entitled to judicial review of the ALJ's decision when such amount exceeds $1,000.

The design of the Part B appeals process (which was incorporated in the original Medicare legislation) reflected two considerations. First, claims under Part B were expected to be relatively small compared to those under Part A. Second, there was a perceived need to prevent the overloading of the courts with minor claims disputes. The U.S. Supreme Court recently held in United States v. Erika Inc., 456 U.S. 201 (1982), that the Part B fair hearing is in fact the final step in the Part B appeals process. The Court stated as follows: 8/

> Conspicuously, the (Medicare) statute fails to authorize further review of Part B awards. In the context of the statute's precisely drawn provisions, this omission provides persuasive evidence that Congress deliberately intended to foreclose further review of such claims . . . the legislative history confirms this view . . .

Since passage of the original Medicare legislation many changes have occurred in the health delivery system. The impact of these changes on the Part B

8/ United States v. Erika, Inc., 456 U.S. 201, 208 (1982).

program have led a number of groups to question whether the existing appeals process should be modified. The recently enacted prospective payment system is creating incentives for reduced lengths of hospital stays thereby placing increased demands on post-hospital services such as skilled nursing facility and home health services which are financed under Part B. Further, many procedures (for example, cataract surgery) which until recently were always performed on an inpatient basis are now frequently performed on an outpatient basis and paid for under Part B. Limited information exists on the dollar impact of these recent system changes. However, policy analysts expect that these changes will lead to an increase in Part B expenditures. It is also expected that requests for carrier reviews and carrier hearings will increase.

B. Due Process

Several court cases have challenged various aspects of the Medicare appeals process on the basis of due process considerations.

One issue raised was the potential violation of due process, since hearing officers were appointed by carriers administering Part B claims. On April 20, 1982, the Supreme Court held in Schweiker v. McClure that this procedure did not violate due process. Specifically the Court held that: 9/

> As this Court repeatedly has recognized, due process demands impartiality on the part of those who function in judicial or quasi-judicial capacities . . . Fairly interpreted, the factual findings made in this case do not reveal any disqualifying interest under the standards of our cases . . . (T)he carriers pay all Part B claims from federal, and not their own, funds. Similarly, the salaries of the hearing officers are paid by the Federal Government.

9/ Schweiker v. McClure, 456 U.S. 188, 195-196 (1982).

In addition, the Court found that additional procedures would not reduce the risk of erroneous decisions since the hearing officers were appointed by the carriers pursuant to specific selections criteria prescribed by the Secretary.

On June 28, 1985, the General Accounting Office (GAO) issued the results of its study on the Medicare Part B appeals process. The letter report 10/ reviewed several court cases which had addressed the question of whether the Part B appeals process as outlined in law and regulations meets the requirements of due process.

The first case reviewed by the GAO was Gray Panthers v. Califano, 466 F. Supp. 1317 (D.C. 1979). In 1977, the Gray Panthers filed a class action suit in the U.S. District Court for the District of Columbia. The suit asserted that the denial of an oral hearing to all beneficiaries with amounts in controversy of less than $100 was an unconstitutional denial of due process. The Court ruled in favor of HHS concluding that the EOMB and the "paper hearing" satisfied the due process requirements. This decision was overturned on appeal by the District of Columbia Court of Appeals in Gray Panthers v. Schweiker, 652 F.2d 146 (1980). The court found that the EOMB used by carriers did not provide an understandable explanation of why benefits were being denied. The court also noted that while the statute did not provide for hearings where the amount in controversy is less than $100, HHS regulations violated due process principles by specifically precluding an oral hearing in all such cases. The court concluded that: 11/

> The present system is flawed by: an inadequate form of notice; a procedure which allows a claimant only a limited opportunity to submit a written reply to an inadequate notice; and a total denial of

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10/ Medicare Part B Beneficiary Appeals Process (GAO Letter No. HRD85-79), June 28, 1985.

11/ Gray Panthers v. Schweiker, 652 F.2d 146, 172 (1980).

> any opportunity for a claimant to participate in any kind of oral interview or consultations with an individual knowledgeable about and empowered to resolve the dispute . . .
>
> We are convinced that simplified, streamlined, informal oral procedures are available which would be responsive to the concerns of Congress for efficiency and low cost yet which would provide claimants with the right to participate in decisions affecting their interests in cases where such participation is critical.

The court therefore remanded the case to the district court in order to allow it, with the assistance of the Secretary of HHS and the plaintiffs, to formulate apropriate revisions of the regulations that would satisfy due process considerations.

In May 1981 the District Court ordered the Department to submit a proposal for resolving the case. HHS's plan, submitted in July 1981, involved minor revisions to the EOMB notice together with the addition of a toll-free telephone system under which a beneficiary could discuss his or her claim with a carrier representative. The District Court rejected HHS's proposal. The Court, in September 1982, ordered HHS to use the Part B notice form proposed by the Gray Panthers and to provide for informal hearings for all Part A and Part B beneficiaries who have less than $100 in dispute.

In 1982, the case again went to the Appeals Court. The Court in Gray Panthers v. Schweiker, 716 F.2d 23 (1983), stated that the District Court had incorrectly read the Appeals Court's earlier decision pertaining to requirements for oral hearings for all beneficiaries dissatisfied with a carrier's or intermediary's decision where less than $100 is in controversy. The court stated that this type of hearing should only be required in a minority of cases such as where the claimant's credibility or veracity were in question. It concluded that the revised EOMB developed by HHS, together with current written review procedures and the proposed HHS toll-free telephone system should be adequate in most cases. The case was remanded to the District Court instructing it to determine whether the revised EOMB met due process requirements and to ensure that the telephone system was implemented.

Subsequent to issuance of the GAO report, a Stipulation was filed on September 5, 1985, in the U.S. District Court for the District of Columbia to resolve outstanding due process challenges in the Gray Panthers case. The Stipulation stated that a mutually satisfactory agreement had been reached for resolving the substance of the Constitutional issues related to Part B. The Stipulation provides for implementation of a new EOMB notice within 120 days of the entry of a final notice by the District Court. It further provides that the revised toll-free telephone system instructions will be in effect on a nationwide basis within 60 days of the entry of a final notice.

The second case reviewed by the GAO was David v. Heckler, F. Supp. 1033 (E.D.N.Y. 1984), which examined the readability of review determination notices. In its decision, District Court found that the notices by which the carrier informed beneficiaries of review determinations:

> . . . are written at a level well beyond most in this segment of the population, with no discernable added benefit from complexity in information provided.
>
> The language used is bureaucratic gobbledegook, jargon, double talk, a form of officialese, federalese and insuranceese, and doublespeak. It does not qualify as English. 12/

The court concluded that the review determination letters issued by the carrier did not provide sufficient information to enable the beneficiary to effectively appeal the carrier's decisions. The District Court ordered the Department to improve both the readability and content of the notices. HHS issued revised instructions for composing such letters in August 1984.

12/ David v. Heckler, 591 F. Supp. 1033, 1043 (E.D.N.Y. 1984).

C. Implementation of Prior GAO Recommendations

The GAO issued two reports 13/ in 1980 and 1981 which examined reasonable charge reductions 14/ and beneficiary underpayments on Part B claims. These reports noted that there was a high risk of underpayment on beneficiary-submitted claims with large reasonable charge reductions. The most common reasons cited for the underpayments were wrong procedure codes, failure to include some procedures, and incomplete description of the diagnosis and/or procedures performed. The reports stated that carrier safeguards were ineffective in preventing these underpayments and made the following recommendations:

--HHS should establish more stringent claims processing standards to prevent underpayments on beneficiary-submitted claims;

--HHS should establish more specific claims processing standards for claims involving large reasonable charge reductions (i.e., when claims should be manually reviewed and what specific action is to be taken as part of the review);

--HCFA, as part of its Contractor Performance Evaluation program and related Carrier Quality Assurance program, should specifically address how well carriers review and resolve claims subject to relatively large reasonable charge reductions.

The GAO letter report issued on June 28, 1985 stated that HHS had not acted to implement the recommendations contained in the 1980 and 1981 reports. The GAO letter report noted that HCFA acknowledged that some beneficiaries receive less reimbursement than they should and that the recommendations could help correct

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13/ Reasonable Charge Reductions Under Part B of Medicare (HRD81-12, October 22, 1980), and More Action Needed to Reduce Beneficiary Underpayments (HRD81-126, September 3, 1981).

14/ Medicare pays for physicians' and most other Part B services on the basis of "reasonable charges." The difference between the physician's actual bill and the amount recognized by Medicare is known as the "reasonable charge reduction." If the physician does not accept assignment (i.e., accept Medicare's determined reasonable charge as payment in full, except for applicable cost-sharing), the beneficiary becomes liable for the reasonable charge reduction amount.

the problem. However, GAO reported that HCFA believed the recommendations would be too costly to administer given current budget constraints and other program priorities.

D. Provider Representation of Beneficiaries

In January 1984, HCFA issued an Intermediary Manual change which prohibited a provider or its employees from representing a beneficiary in a Part A appeal. This change from previous policy was made primarily because HCFA felt there were potential conflicts of interest in such a practice. Under the previous policy, a provider who had no appeal rights (because all of the denied services had been paid for under the waiver of liability provision) could obtain such a right by having the beneficiary appoint it as his representative. While the beneficiary may not be interested in pursuing an appeal, the provider may wish to appeal to protect its favorable waiver of liability presumption or to appeal a coverage determination. A provider's and beneficiary's interest may also conflict because a beneficiary rather than a provider will be considered to have received an overpayment if the provider can show it was without fault and acted in good faith.

The HCFA's previous policy has been challenged on the basis that the potential conflict of interest did not in fact pose real problems. Beneficiary groups have recommended that the right of beneficiaries to be represented by providers be restored. It has been suggested by beneficiary and provider groups that the beneficiary would benefit in presenting his appeal because of the provider's familiarity with Medicare policies and procedures and the fact that providers will have better access to the information needed to present the beneficiaries' claims.

E. Coalition Recommendations

In early 1985, a broad-based coalition 15/ of beneficiary groups, provider associations, practitioners, and suppliers examined the appeals process and procedural protections under the Medicare program. This coalition identified a number of problems which they felt existed under the current system and prepared a package of recommended modifications to the statute designed to address these problems. The coalition recommended expanding the appeals process under Part B and permitting provider representation of beneficiaries in the appeals process (see discussion of these issues above). In addition, the coalition recommended a number of additional changes including the following:

- Patient Notification--Require that written notice be given to every Medicare patient 48 hours prior to discharge from a hospital, skilled nursing home, or home health agency. The notice would contain information concerning the reason for discharge and how to appeal the discharge to the PRO or fiscal intermediary.
- PRO Appeals--Allow providers to appeal PRO determinations on the merits. A provider would be given the same appeal rights as a beneficiary (i.e., access to administrative law judge and judicial review of PRO reconsiderations). Providers would also be permitted, where important Medicare coverage questions are at issue, to group claims which would not otherwise exceed the statutory limits.
- Access to Courts--Provide immediate access to the courts for providers, practitioners, and beneficiaries to challenge a final rule of the Secretary [Currently, they have to exhaust administrative remedies. In the case of reimbursement questions, providers must wait until they receive the Notice Program Reimbursement for the cost reporting period in question, before they can appeal. This interpretation has recently been declared invalid by the U.S. District

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15/ The coalition includes representatives from: The Catholic Health Association, American Protestant Hospital Association, American Hospital Association, American Health Care Association, American Association of Homes for the Aging, Federation of American Hospitals, National Association of Medical Equipment Suppliers, American Speech Language and Hearing Association, American Federation of Home Health Agencies, National Association of Public Hospitals, American Association of Retired Persons, National Council of Senior Citizens, National Senior Citizens Law Center, American Medical Association, American Bar Association, and National Association of Home Care.

Court for the District of South Carolina with respect to appeals of hospital-specific base year costs under PPS].

- Retroactivity of Successful Appeals--Provide that successful appeals of payment amounts under PPS shall be given retrospective [rather than prospective] application.

- Application of Administrative Procedure Act (APA) Standards--Require the Secretary to follow the procedures delineated in the APA (including notice of proposed rule-making) when issuing any regulation or rule relating to Medicare. Persons hearing appeals and/or rendering decisions would be bound only to statutes and regulations published in accordance with the APA (currently they are also bound by manuals, intermediary letters, and similar issuances).

- Appeal of Certain Coverage Denials--Allow providers [as well as beneficiaries] to appeal coverage denials such as those based on a beneficiary not meeting specified requirements for home health services (e.g., "homebound," and in need of "intermittent" skilled nursing care).

- Provider Reimbursement Review Board (PRRB)--Make the following modifications to PRRB requirements:

  --Permit extension for good cause, of the statutory 180-day limit for filing appeals with the PRRB.

  --Require PRRB decisions to state the facts on which opinions are rendered. [Decisions are required by law to be supported by substantial evidence].

  --Add reasonableness standard to the PRRB's ability to make rules and establish procedures governing its own operations.

  --Remove Secretary's authority to reverse, affirm, or modify PRRB decisions within 60 days. The Secretary would be given the right to obtain judicial review of the final decision.

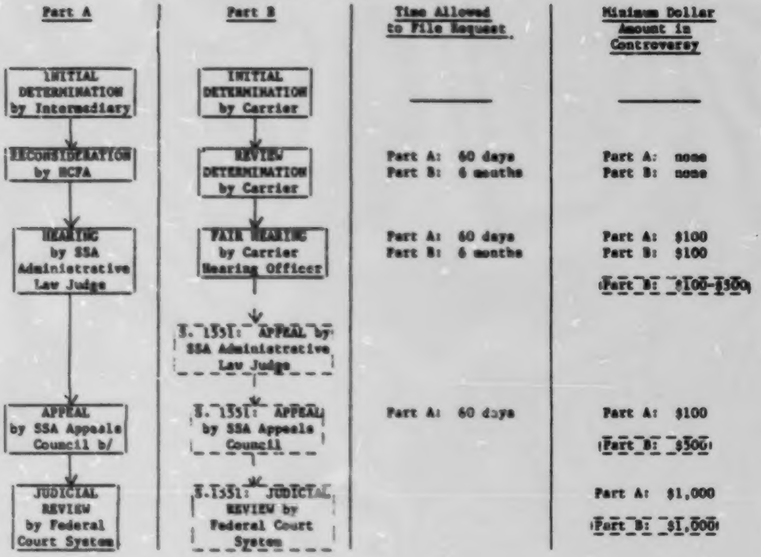
V. "FAIR MEDICARE APPEALS ACT OF 1985" (S. 1551)

On August 1, 1985, Senators Durenberger, Heinz and Chafee introduced S. 1551, the "Fair Medicare Appeals Act of 1985." This legislation would make the following modifications in current appeals procedures:

- Where the amount in controversy under Part B was between $100 and $500, the appeal would continue to be settled by the carrier.
- Where the amount in controversy was over $500, the beneficiary could appeal the carrier's determination to an administrative law judge.
- Where the amount in controversy was over $1,000, the beneficiary would be entitled to judicial review of the ALJ's decision.
- For purposes of determining the amount in controversy, the Secretary under regulations, would allow two or more claims to be aggregated if the claims involved the delivery of similar or related services to the same individual or involved common issues of law and fact arising from services furnished to two or more individuals.
- Beneficiaries could choose to be represented by providers which furnished the services in appeals procedures under both Part A and Part B.

MEDICARE APPEALS PROCESS

Part A Appeals are made by the Beneficiary or Provider a/
Part B Appeals are made by the Beneficiary or the Physician or
Supplier who Accepted Assignment


Part A
Part B
Time Allowed to File Request
Minimum Dollar Amount in Controversy
INITIAL DETERMINATION by Intermediary
INITIAL DETERMINATION by Carrier
RECONSIDERATION by HCFA
REVIEW DETERMINATION by Carrier
Part A: 60 days
Part B: 6 months
Part A: none
Part B: none
HEARING by SSA Administrative Law Judge
FAIR HEARING by Carrier Hearing Officer
Part A: 60 days
Part B: 6 months
Part A: $100
Part B: $100
Part B: $100-$500
S. 1351: APPEAL by SSA Administrative Law Judge
APPEAL by SSA Appeals Council b/
S. 1351: APPEAL by SSA Appeals Council
Part A: 60 days
Part A: $100
Part B: $500
JUDICIAL REVIEW by Federal Court System
S.1351: JUDICIAL REVIEW by Federal Court System
Part A: $1,000
Part B: $1,000

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a/ If a beneficiary appeals an initial determination, the provider is made a party to the reconsideration process. A provider may initiate a request for reconsideration only if the liability rests with the provider or the beneficiary and the beneficiary has indicated in writing that he or she does not wish to appeal. If, however, Medicare has made payment for all noncovered items and services under the "waiver of liability" provision, the provider has no right to appeal nor is it made a party to the determination if the beneficiary appeals.

b/ Appeals Council may deny request.

BEST COPY AVAILABLE

Senator **Durenberger**. I want to welcome you all this morning to the subcommittee's hearing on S. 1551, the Fair Medicare Appeals Act of 1985.

I want to thank my colleagues from the States of Rhode Island and Pennsylvania, who joined me in the introduction of this legislation, and the Congressman Ron Wyden, who is with us this morning to introduce the House version of the bill, H.R. 2864, which was included in the Energy and Commerce Budget Reconciliation Package.

The appeals processes provided under Medicare, parts A and B, are not simple. The hearing will provide the forum needed to work out the technicalities of reform, to the extent that the witnesses confirm our instincts that reform is necessary.

We will look at S. 1551, reform of appeals under part B, and also consider suggestions for reform of the appeals process under part A. Part B appeals were modeled after Aetna's Federal employee health benefit plan.

When part B was designed, claims were relatively small compared to part A, Medicare's Hospital Insurance Program. It was the intent of Congress to limit judicial review of part B claims to prevent the needless overloading of the courts with minor claim disputes.

Yet, this isn't the same health care system it was 20 years ago. More than ever before, medical treatment is being delivered in the doctor's office, in the hospital outpatient department, in ambulatory surgery centers, and in the home, most of which is covered under part B.

Given this trend, it concerns me greatly that under part B there is no provision for judicial review of claims disputed by beneficiaries. For amounts over $100, appeals are heard only by a hearing officer, who is not only appointed by the carrier but employed by him as well. There is no further review for the Medicare beneficiary beyond the carrier level.

We will hear later this morning the case about one beneficiary's experience with the Medicare appeals process. The hearing officer, in a dispute over a claim of $1800, showed neither compassion nor understanding of the beneficiary's appeal.

I feel strongly that each beneficiary should be guaranteed the right to appeal a carrier's decision. That is why we are having this hearing this morning, and why I have put Medicare appeals on my list of legislative priorities.

We will also look at the appeals process available to beneficiaries and providers who are dissatisfied with a PRO decision under part A. This, of course, is more difficult; providers are limited to reconsideration by the PRO, while the beneficiary is provided an appeal beyond the PRO. Yet, the amounts triggering the rights to appeal a PRO decision are set at higher levels than for other part A appeals and for the levels established by S. 1551 for part B.

There are other factors in this one that complicate it, as well, and we hope to address those issues this morning.

I look forward to hearing from all of our witnesses. We have more than the usual number, so we will stick more closely to our 5-minute limit in the presentations, with the exception of our first two witnesses, the first of which is the Honorable Ron Wyden, U.S. House of Representatives, from the State of Oregon.

Ron, thank you very much for being here, and your full statement will be made a part of the record, as will those of all the other witnesses.

Thank you.

STATEMENT OF THE HONORABLE RON WYDEN, U.S. HOUSE OF REPRESENTATIVES, STATE OF OREGON

Congressman **WYDEN**. Thank you very much, Mr. Chairman.

First, let me express my appreciation to you, Mr. Chairman, that you and I have had a chance to work on a whole host of issues, from prospective payment, long-term care, and now Medicare appeals. And I just want to tell you, Mr. Chairman, in my view you have great sensitivity and a great commitment to the issues important to the citizens of this country, and I am very appreciative that I had a personal invitation to appear here today.

Senator **DURENBERGER**. Thank you very much.

Congressman **WYDEN**. Mr. Chairman, I would ask that my statement be put in the record. But if I could just highlight a few principal concerns that I think are particularly important, I could do this in a very expeditious way.

The first thing I would like to mention, Mr. Chairman, is that the policy yesterday in the reconciliation bill included the legislation that you and I introduced earlier here on June 25. The House version, H.R. 2864, the Fair Medicare Appeals Act, was adopted by the House yesterday. This legislation, in my view, is much needed, because in the Government's efforts to cut Medicare costs it has cut back on the legitimate rights of our older people.

Today you are going to hear a very personal story about why we need the kind of changes that you and I advocate in our legislation. Arlene Lapp, one of my constituents from Portland, OR, will describe her predicament which clearly demonstrates the need for our legislation. I am going to let her tell her story; I think she can do it far more eloquently than I could, and I would just like to spend a minute or two describing what our legislation will do.

In a nutshell, it would give older people a fair opportunity to appeal the denial of hospital benefits under Medicare part A, and in addition it would bring fairness to the appeals process for Medicare part B which, as you said, Mr. Chairman, applies to a variety of outpatient services.

Just a word or two about the part A section of the legislation. Sometimes the Federal Government makes a complete 180-degree turn in health policy and starts heading in the wrong direction. That is what has happened under Medicare part A, the appeals section, this year.

For years, our older people had the commonsense choice of being able to work together with their health care provider in an appeals procedure. Then, without any public comment, testimony, or any formal consideration whatsoever, the Health Care Administration sought to cut off that choice. So, today an older person doesn't have the option of working together with his health care provider on an appeal.

The reason that was given by the Health Care Financing Administration was that the system was being abused.

In an earlier hearing, I asked the Administration about it, a hearing in the Energy and Commerce Committee, and they could offer, in the entire Nation, just one possible case where there was an abuse—just one possible case in the entire Nation was their grounds for denying all the older people in this country the chance to appeal with their provider, working together in a cooperative way. In my view, Mr. Chairman, that is just not right.

Now, setting aside the question of the unfairness in the part A appeals process, let me describe briefly why I think part B is inadequate and, in effect, just very much out of date.

As recently as 3 years ago, part B represented only small claims, and there was only a rudimentary appeals process. And I think there was a general consensus among consumer advocates and providers and others that that was appropriate. But today, because of the prospective payment legislation, the ball game is very, very different, and more and more care today takes place outside the hospital; and so, the States, with respect to part B, have gotten much, much more important and the claims much bigger.

So, what I want to see us do is bring the part B appeals system up to speed and put it in line with the times.

As of now, the part B beneficiaries are the only people in this country with health insurance who don't have access to our Nation's justice system. If you've got private insurance, if you receive care from the military, if you've got Medicaid, if you are part of all of these other programs, you can have a day in court; but not if you have Medicare part B. I don't think that is right, and I think that is what needs to be changed.

Now, we are going to hear from HCFA later today that, because some of the decisions have gone in favor of the beneficiaries—some of them—that, again, we don't need to change the appeals process, that it is working just fine. But I would suggest, first of all, that even some of those cases that have gone in favor of the older person under part B, there has only been a partial payment. And it seems to me that making only a small partial payment on a very large claim is not grounds to say that the system is working very well. We also know that 40 percent of the people don't get anything; their claims are simply denied. So, I think the case that the Medicare part B appeals process works well because some people get a partial payment in this country, again, is just not founded.

So, Mr. Chairman, I would like to see us update the system, give senior citizens the rights they deserve, to have an administrative law judge examine the question and finally have access to the courts. That is what our legislation does, which I think now has some momentum behind it.

I just want to tell you again that I am very grateful for the chance to work with you. I think you are going to very much enjoy listening to my constituent Ms. Arlene Lapp, who I think has an important story to tell.

I also will just mention that the coalition that supports our legislation, Mr. Chairman, doesn't come together very often. We are going to hear that the American Medical Association, the Grey Panthers, and the AARP—all groups directly affected with the quality of care in this country—have joined hands in back of our bill. And, as we know, that is a coalition that doesn't always come together behind every issue. And I think it is evidence of how serious the injustices are in our current system and why our bill is so very much needed to correct it.

With that, Mr. Chairman, I am going to break my orating off and say, again, my thanks to you.

Senator **Durenberger**. Well, thank you very much, and I appreciate all of your efforts on a wide variety of policy issues. This is one that I know both of us feel very strongly about.

I feel less strongly the urgency to have to go over and vote right now. It is one of those 99-to-nothing votes we do around here to keep our percentages up. [Laughter.]

Senator **Durenberger**. So, Ron, thank you very much for your testimony. My apologies for the inconvenience of everyone else, and my apology to Henry, who must be the first one to wait. I am going to absent myself for as little a time as possible to go over and vote, and I will be right back.

Ron, thank you. I take it Arlene comes later in a panel, right?

Congressman **Wyden**. She will be up very shortly. And, again, we appreciate your consideration.

Senator **Durenberger**. Thank you very much.

Congressman **Wyden**. Thank you.

[Whereupon, at 10:10 a.m., the hearing was recessed.]

[Congressman Wyden's prepared statement follows:]

TESTIMONY ON MEDICARE APPEALS
CONGRESSMAN RON WYDEN
NOVEMBER 1, 1985

IT'S A MATTER OF FAIR PLAY

Mr. Chairman, Senator Durenberger -- I am pleased to have the opportunity to testify today about a crying need in our Medicare system: a new and fairer way to appeal denial of coverage. I want to commend at the outset the Chairman and the members of this Subcommittee for their willingness to consider this important matter.

Yesterday the House, in its reconciliation bill, included H.R. 2864, the Fair Medicare Appeals Act, which I introduced on June 25, 1985. This legislation is much needed because in the government's efforts to cut Medicare costs it has cut back on the legitimate rights of our senior citizens.

Today you will hear a very personal story about why we need these changes. Arlene Lapp, one of my constituents from Portland, Oregon, will describe her predicament which clearly demonstrates the need for this legislation. I will let her tell her story.

I would like to take just a couple of minutes and describe what my legislation will do. In a nutshell, it would give senior citizens a fair opportunity to appeal the denial of hospital benefits under Medicare Part A and would bring fairness to the appeals process for Medicare Part B which applies to a variety of outpatient services.

Let me talk about the Part A section of the legislation first. Sometimes the federal government makes a complete 180 degree turn in health policy and starts heading due backwards. That is what happened under Medicare Part A appeals this year.

For years, senior citizens had the common sense choice of being represented by their doctor or hospital in an appeals proceeding. Then, without public comment, testimony or consideration, the Health Care Financing Administration cut off that choice.

Now a senior citizen doesn't have the option of working with their doctor or hospital in an appeal. The reason? HCFA says that this system was being abused. Their proof? Only one case they could show us.

Mr. Chairman, this is plainly unfair.

And while the Part A appeals process is unfair, the Part B system is at best inadequate and at worst grossly out of date.

As recently as three years ago, Part B represented only small claims and there was only a rudimentary appeals process. But under the new prospective payment system, more and more care is taking place outside the hospital and Part B claims are getting bigger. The appeals system needs to be brought up to speed and made just as thorough and even-handed as the current Part A appeals system.

Right now, Part B beneficiaries are the only people in this country with health insurance who do not have access to our nation's justice system. If you have private insurance, if you have Medicare Part A insurance, if you receive care from the Military, if you have Medicaid, you can ultimately have your day in court. But not if you have Medicare Part B. If you don't agree with the fair hearing officer's decision -- tough!

And what does HCFA say about this? They say that Part B fair hearing officers decide more than 60% of the cases in favor of the beneficiary. But that 60% includes many cases where HCFA makes only partial payment. Getting $100 more on a $1500 claim is not much of a victory. It's no victory when there is no recourse. And what about the other 30% to 40% who have no avenue of complaint when the judgment is against them?

All this means we need to update the system. It means seniors should have access to reviews by Administrative Law Judges and should finally have access to the courts to adjudicate these matters. That is what my legislation does in the House and what the legislation you are now considering would also do.

The legislation would ensure that people like Arlene Lapp get the fair shake they deserve -- not a song and dance from the Health Care Financing Administration.

Before I close today, I want to compliment a wide-based group of organizations that have helped make the case for this important legislation. The Medicare Appeals Coalition, a representative of which will testify with Ms. Lapp, ranges in membership from the American Association of Retired Persons to the American Medical Association. And any time you have those two groups under one roof, you know you have a pretty powerful group with a pretty powerful argument.

Those organizations came together to correct the injustices in our current system. They came together, and I have joined them, because seniors are now getting a raw deal when they disgree with the government's decisions. That's not fair play. It is time to right this wrong. I urge you to move quickly -- as we have done in the House -- on the legislation before you.

Thank you.

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AFTER RECESS

Senator **Durenberger**. The hearing will come to order.

Our next witness is Dr. Henry Desmarais, the Acting Deputy Administrator of the Health Care Financing Administration, also known as HCFA.

Henry, your statement will be made part of the record, and you may proceed to summarize it. Thank you for being here.

STATEMENT OF HENRY DESMARAIS, M.D., ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. **Desmarais**. Thank you, Mr. Chairman. I am happy to be here with you this morning as the committee reviews the administrative review and appeal procedures under Medicare and related legislation, S. 1551, introduced by you and several of your colleagues.

Let me begin by saying that we make every effort to inform beneficiaries of their appeal rights. This begins from the moment they receive the Medicare handbook at the time they become eligible for the program. It comes in the form of pamphlets we make available to them and it comes in the form of the "Explanation of Medicare Benefits," which is sent to them when each claim is processed. We also have toll-free lines, and in fiscal year 1984, 6 million calls were received on those toll-free lines that are provided by Medicare contractors.

It would be good to take a few moments and just briefly describe the available appeal rights now under current law.

First, under part A there are two avenues, and the avenues depend upon who the initial deciding entity was. The first avenue, of course, involves the peer review organizations, and that is relevant for inpatient hospitals. If there is dissatisfaction with their decision, the beneficiary, the provider, and/or the physician may ask for a reconsideration by the PRO. If the decision at that point is still unsatisfactory, a further appeal is available, but only to the beneficiary, as you have correctly pointed out, and not to the provider or the physician. And if the amount in disagreement is $200 or more, the beneficiary does have the right to ask for an ALJ hearing, and then on from there to the appeals council, and, furthermore, into district court if the amount in contention is at least $2,000.

The second avenue under part A has to do with the fiscal intermediaries, and that is particularly important now for home health and for skilled nursing facility claims, and less so for hospital claims, which are really under the PRO Program. Again, reconsideration rights, ALJ rights, and court rights are available. The thresholds are different, though; they are lower on the fiscal intermediary side, probably because they were put into statute back in 1972.

On the part B side the situation is somewhat different: In fiscal year 1984 there were 226 million claims under part B, which is about five times the number of claims we have under the part A side. If there is a dissatisfaction with the findings of our contractor—the carrier, in this case—a request can be made for a review. And in fiscal year 1984 we had about 3 million such requests. And at that point, it is the carrier's personnel, different personnel, that will review the case and will consider any additional information that can be submitted at that time.

In fact, what we find [illegible] the claim is frequently perfected through this process, and essential information that had been left off the claim is finally provided, and a proper decision can be reached.

Going from there, if there is continued dissatisfaction and the amount in contention is at least $100, then there is an opportunity for a carrier-held fair hearing. And in fiscal year 1984 there were 30,000 such requests. As has been pointed out repeatedly, there is no further appeal under current law.

Let me turn briefly to S. 1551.

Suffice it to say that we don't believe that the provisions in that bill are needed at this time. We really believe that current appeal opportunities are adequate. We have received minimal beneficiary complaint about those processes. To those who might say they are not fair or impartial, because they are held at the carrier rather than before an ALJ, I would respond that the number of reversals certainly argues against that contention.

I might point out, more specifically, that in fiscal year 1984, at the reconsideration level, 57 percent of those reconsiderations were reversed in full or in part; and, in fact, at that level half of those reversals were full reversals—not partial reversals but full reversals. Furthermore, at the fair hearing level, in fiscal year 1984, 62.8 percent were also reversed at that level. In this case, however, the bulk of those reversals are partial reversals only.

To those who might say due process is violated, I would respond that the Supreme Court in a unanimous decision concluded otherwise.

I think we need to point out that under the provisions of this bill, we estimate, it would cost between $11 million and $17 million in additional costs to run this kind of program.

Let me turn for a moment to the issue of provider representation of beneficiaries for part A appeals. This reflects the January 1984 policy clarification that we promulgated.

It is a little difficult to talk about this issue at this moment because of pending litigation in the U.S. District Court in the District of Columbia. However, let me say first, it is very clear from the statute that beneficiaries have certain appeal rights and that providers have other appeal rights, and that those appeal rights are narrowly defined. It was our conclusion that allowing the provider to represent the beneficiary would certainly cloud, and I would say undermine, those distinctions that are statutorily based.

We also have pointed out the potential for conflict of interest, because this whole process may determine that one of the parties was financially responsible. If that turns out to be the beneficiary, then one would wonder whether in fact the provider provided the help that the beneficiary truly needed.

We also have evidence that beneficiaries are being misled by providers. They are being told to sign appeal forms; they are being told to ask for the provider to represent the beneficiary. In this way, as I said, they are attempting to secure appeal rights that are not really rightfully theirs. This may explain, in part, why the opposition to our current policy comes chiefly from providers and not from beneficiaries.

Let me end by saying that we believe the process is adequate. It is working. I am not saying it is perfect. We do invest a great deal of energy in monitoring how well our contractors do, how well the ALJ's do, and we continue to make improvements in that process—for example, improved beneficiary notifications that are readable and provide all of the information the beneficiary needs.

Let me end now and stand ready for your questions.

[Dr. Desmarais' statement follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

HENRY R. DESMARAIS, M.D.

ACTING DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

NOVEMBER 1, 1985

INTRODUCTION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I WELCOME THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO DISCUSS THE ADMINISTRATIVE REVIEW AND APPEAL PROCEDURES UNDER THE MEDICARE PROGRAM AND S. 1551, THE "FAIR MEDICARE APPEALS ACT OF 1985." WE SHARE A MUTUAL CONCERN FOR PROTECTING THE RIGHTS OF MEDICARE BENEFICIARIES TO QUESTION A PAYMENT DECISION ON A CLAIM. WE BELIEVE THAT THE USE OF APPEAL PROCEDURES BY BENEFICIARIES CAN BE IMPORTANT BAROMETERS OF THE PUBLIC'S PERCEPTION OF THE EFFICIENCY AND EQUITY OF THE MEDICARE PROGRAM. I LOOK FORWARD TO EXCHANGING VIEWS WITH YOU ON THIS IMPORTANT TOPIC.

BACKGROUND

MR. CHAIRMAN, I WOULD LIKE TO BEGIN MY DISCUSSION BY DESCRIBING THE EFFORTS WE HAVE MADE TO ASSURE THAT MEDICARE BENEFICIARIES ARE FULLY AWARE OF THEIR RIGHTS TO APPEAL A DECISION ON A CLAIM. WHEN AN INDIVIDUAL BECOMES ENTITLED TO MEDICARE BENEFITS, A BOOKLET ENTITLED "YOUR MEDICARE HANDBOOK" IS PROVIDED AT THE SAME TIME AS THEIR MEDICARE CARD. THIS BOOKLET EXPLAINS THE MEDICARE PROGRAM AS WELL AS THE BENEFICIARY'S RIGHT TO APPEAL. SEVERAL OTHER PUBLICATIONS ON THE MEDICARE APPEALS PROCESS ARE ALSO AVAILABLE. WHEN A CLAIM IS FILED, THE BENEFICIARY RECEIVES A WRITTEN EXPLANATION OF

THE ACTION TAKE ON EACH CLAIM AND THE STEPS TO BE TAKEN IF THE BENEFICIARY IS NOT SATISFIED WITH THE DETERMINATION. IN ADDITION, SOCIAL SECURITY OFFICES, AS WELL AS OUR MEDICARE CONTRACTORS, ARE AVAILABLE TO THE PUBLIC TO HELP ANSWER QUESTIONS DEALING WITH THE MEDICARE APPEALS PROCESS. MEDICARE CONTRACTORS HAVE TOLL FREE TELEPHONE NUMBERS AVAILABLE FOR THE BENEFICIARY'S CONVENIENCE.

PART A APPEALS PROCEDURES

I WOULD NOW LIKE TO DESCRIBE THE CURRENT MEDICARE REVIEW AND APPEAL PROCEDURES UNDER THE HOSPITAL INSURANCE (PART A) PROGRAM. THERE ARE TWO APPEAL MECHANISMS AVAILABLE TO BENEFICIARIES UNDER THE PART A PROGRAM: ONE IS THROUGH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS (PROs) AND THE OTHER IS THROUGH THE MEDICARE INTERMEDIARIES. THE CHOICE OF APPEAL MECHANISM DEPENDS UPON WHO MADE THE INITIAL DENIAL DETERMINATION. AS YOU KNOW, PROs ARE ORGANIZATIONS COMPOSED OF LOCALLY PRACTICING PHYSICIANS IN EACH STATE WHO HAVE ASSUMED A CONTRACTUAL RESPONSIBILITY FOR COMPREHENSIVE AND ONGOING REVIEW OF HOSPITAL INPATIENT SERVICES REIMBURSED UNDER THE MEDICARE PROGRAM. A PRO DETERMINES WHETHER SERVICES ARE REASONABLE AND MEDICALLY NECESSARY, PROVIDED IN THE APPROPRIATE SETTING, AND ARE OF A LEVEL OF QUALITY THAT MEETS PROFESSIONALLY RECOGNIZED STANDARDS.

HOSPITALS MUST INFORM MEDICARE BENEFICIARIES, IN WRITING AT THE TIME OF THEIR ADMISSION, ABOUT WHAT MEDICAL SERVICES ARE COVERED UNDER MEDICARE AND THE GENERAL PROCESS OF HOW DECISIONS ARE MADE ON THEIR CLAIMS. HOSPITALS MUST ALSO PROVIDE BENEFICIARIES WITH INFORMATION WHICH CLEARLY EXPLAINS THAT THEY DO HAVE AVENUES OF RECOURSE IN THE EVENT THEY DO NOT AGREE WITH THE DECISION ON THEIR CLAIM. TO ENSURE THAT THESE ACTIVITIES ARE CARRIED OUT, WE RECENTLY ISSUED ADDITIONAL DIRECTIVES TO THE PROS RECONFIRMING OUR COMMITMENT TO MAKE BENEFICIARIES FULLY AWARE OF THEIR RIGHTS AND RESPONSIBILITIES UNDER THE PROGRAM. AS A FURTHER STEP TO ENSURE THAT OUR BENEFICIARIES ARE FULLY INFORMED OF THEIR RIGHTS, WE ARE DEVELOPING AN INFORMATIONAL BROCHURE TO BE GIVEN TO BENEFICIARIES WHEN THEY ARE ADMITTED TO A HOSPITAL. THIS BROCHURE WILL EXPLAIN WHAT PROS ARE, THE CLAIMS REVIEW PROCESS, AND HOW TO GET IN CONTACT WITH THE PRO.

IN CASES WHERE A BENEFICIARY DOES NOT AGREE WITH A PRO DETERMINATION ON HIS CLAIM, HE HAS THE RIGHT TO A RECONSIDERATION BY THE PRO. IN A RECONSIDERATION, THE PRO MAKES A SEPARATE DETERMINATION ON THE CLAIM, EITHER AFFIRMING OR REVISING THE INITIAL DETERMINATION. THE REQUEST FOR A RECONSIDERATION MUST BE MADE WITHIN 60 DAYS. IF THE BENEFICIARY DOES NOT AGREE WITH THE RECONSIDERATION DECISION and the amount in question is $200 or more, the law provides that he may request a hearing by an Administrative Law Judge (ALJ). ALJ's are employees of the Office of Hearings and Appeals (OHA) of the Social Security Administration and are appointed by the Secretary under the Administrative Procedures Act. OHA has the responsibility for ALJ review of all benefit and entitlement appeal cases for programs under the Social Security Act. Medicare part A cases are assigned to ALJ's on a rotating basis along with claims under other programs. A provider's appeal rights under the PRO process are more limited than those of a beneficiary. A provider has only the right to a PRO reconsideration. It is not entitled to challenge the PRO denial beyond the initial level of appeal.

In instances where the beneficiary disagrees with the decision of the administrative law judge he may request a review of his claim by the Appeals Council of the Office of Hearings and Appeals. Where the Appeals Council's decision is unfavorable to the beneficiary, or the Council denies a request for a review, the beneficiary has the right to judicial review of the Council's decision if the amount at issue is $2,000 or more.

BASICALLY, THE SAME APPEALS PROCEDURES PROVIDED TO A BENEFICIARY BY A PRO ARE AVAILABLE TO HIM UNDER THE MEDICARE INTERMEDIARY APPEAL MECHANISM. THAT IS, IF A BENEFICIARY DOES NOT AGREE WITH AN INTERMEDIARY'S INITIAL DETERMINATION ON HIS CLAIM, HE HAS THE RIGHT TO A RECONSIDERATION BY THE INTERMEDIARY. THE REQUEST FOR A RECONSIDERATION MUST BE MADE WITHIN 60 DAYS AFTER THE BENEFICIARY RECEIVES THE INITIAL DETERMINATION.

FURTHER ADMINISTRATIVE AND JUDICIAL REVIEW, SIMILAR TO THE PRO APPEAL PROCEDURES, IS AVAILABLE TO THE BENEFICIARY IF HE IS DISSATIFIED WITH THE INTERMEDIARY'S REVIEW DECISION. HOWEVER, THERE ARE SOME DIFFERENCES IN THE QUALIFYING AMOUNTS PROVIDED IN THE STATUTE FOR HEARINGS AND APPEALS. IN ORDER FOR A BENEFICIARY TO RECEIVE AN ALJ HEARING THE AMOUNT IN CONTROVERSY MUST BE AT LEAST $100. FOR JUDICIAL REVIEW THE QUALIFYING AMOUNT IS $1,000.

PART B APPEALS PROCEDURES

AS YOU KNOW, UNDER THE MEDICARE SUPPLEMENTARY MEDICAL INSURANCE (PART B) PROGRAM, CARRIERS MAKE THE INITIAL DETERMINATION WHEN A REQUEST FOR PAYMENT OF BENEFITS IS SUBMITTED. THE CARRIER DECIDES WHETHER SOME OR ALL OF THE SERVICES ARE COVERED AND WHETHER THE CHARGE FOR THE SERVICES

MEETS THE STATUTORY DEFINITION OF "REASONABLE." THE CARRIER MAY EITHER DENY THE CLAIM OR MAKE PAYMENT ON THE BASIS OF THE MEDICARE APPROVED AMOUNT. CLAIMS ARE REVIEWED USING PROFESSIONALLY DEVELOPED MEDICAL SCREENS WHICH SERVE AS GUIDELINES FOR PROCESSING CLAIMS. IN ADDITION, REVIEWERS HAVE ACCESS TO PROFESSIONAL MEDICAL STAFF EMPLOYED BY THE CARRIER FOR MAKING DECISIONS IN QUESTIONABLE CASES.

A BENEFICIARY WHO IS DISSATISFIED WITH THE CARRIER'S DECISION HAS THE RIGHT TO REQUEST A REVIEW OF HIS CLAIM. REVIEWS ARE MADE BY THE CARRIER REGARDLESS OF THE AMOUNT IN CONTROVERSY. IN FY 1984, THERE WERE 2.9 MILLION REQUESTS FOR REVIEWS FROM A TOTAL OF 226 MILLION PART B CLAIMS THAT WERE PROCESSED. IN THE REVIEW, THE CARRIER EXAMINES ALL THE PERTINENT MEDICAL EVIDENCE, INCLUDING ANY ADDITIONAL DOCUMENTATION THE BENEFICIARY MAY SUBMIT, AND THEN MAKES A DECISION ON THE CLAIM. REVIEWS ARE CONDUCTED BY CLAIMS ADJUSTORS WHO WERE NOT INVOLVED WITH THE ORIGINAL DECISION ON THE CLAIM. THE ONLY RESTRICTION PLACED ON REVIEWS IS THAT A REQUEST MUST BE FILED WITHIN SIX MONTHS OF THE DATE OF THE "EXPLANATION OF MEDICARE BENEFITS" WHICH IS SENT TO THE BENEFICIARY WHEN A DECISION IS MADE ON A PART B CLAIM.

IF THE BENEFICIARY DISAGREES WITH THE CARRIER'S DECISION REGARDING HIS CLAIM AFTER THE RECONSIDERATION, HE MAY REQUEST A HEARING BY THE CARRIER. A BENEFICIARY IS ENTITLED TO A

CARRIER HEARING ONLY IF THE AMOUNT IN CONTROVERSY IS $100 OR MORE AND THE HEARING REQUEST IS FILED WITHIN 6 MONTHS OF THE REVIEW DETERMINATION. TO MEET THE $100 MINIMUM, A BENEFICIARY MAY COUNT OTHER CLAIMS HE HAS FILED WHERE PAYMENT AMOUNTS ARE AT ISSUE THAT HAVE BEEN REVIEWED WITHIN THE PAST 6 MONTHS. THE BENEFICIARY IS NOTIFIED OF THE PLACE, DATE AND TIME OF THE CARRIER HEARING. HE MAY PRESENT ADDITIONAL INFORMATION AND MAY APPEAR PERSONALLY AT THE HEARING OR HAVE SOMEONE ELSE REPRESENT HIM IF HE CHOOSES.

THE HEARING OFFICER, WHO IS APPOINTED BY THE CARRIER RESPONSIBLE FOR HANDLING THE CLAIM, WILL NOT HAVE BEEN INVOLVED IN THE INITIAL OR REVIEW DETERMINATON MADE ON THE BENEFICIARY'S CLAIM. IN FY 84 THE CARRIERS RECEIVED APPROXIMATELY 30,000 REQUESTS FOR HEARINGS. THE AVERAGE AMOUNT IN CONTROVERSY FOR THESE CLAIMS WAS UNDER $1,000. THUS, REQUESTS FOR HEARINGS REPRESENTED LESS THAN ONE PERCENT OF THE REVIEWS THAT WERE REQUESTED AND REPRESENTS AN EXTREMELY SMALL PROPORTION OF ALL PART B CLAIMS.

AS YOU KNOW, CURRENT LAW DOES NOT PROVIDE FOR AN APPEAL ON REIMBURSEMENT ISSUES BEYOND THE DECISION OF THE CARRIER'S HEARING OFFICER ON A PART B CLAIM; NOR IS THERE A STATUTORY

RIGHT TO JUDICIAL REVIEW. HOWEVER, BENEFICIARIES DO HAVE THE RIGHT TO JUDICIAL REVIEW IN CASES CONCERNING ELIGIBILITY TO ENROLL, OR DETERMINATIONS ON WHETHER THE INDIVIDUAL IS ENROLLED IN THE PART B PROGRAM.

S. 1551, THE FAIR MEDICARE APPEALS ACT OF 1985

I WOULD NOW LIKE TO DISCUSS THE DEPARTMENT'S VIEWS ON THE PROVISIONS OF S. 1551, "THE FAIR MEDICARE APPEALS ACT", WHICH IS THE FOCUS OF THIS HEARING. S. 1551 WOULD PROVIDE THAT THE CARRIER SETTLE ALL DISPUTES ON CLAIMS WHERE THE AMOUNT IN CONTROVERSY IS $500 OR LESS. WHERE THE PAYMENT DISPUTE IS GREATER THAN $500, THE BILL WOULD SUBSTITUTE A HEARING BY AN ADMINISTRATIVE LAW JUDGE IN LIEU OF A CARRIER HEARING. IF THE BENEFICIARY IS NOT SATISFIED WITH THE ALJ'S DECISION AND THE AMOUNT IN DISPUTE IS GREATER THAN $1,000, THE BENEFICIARY WOULD HAVE THE STATUTORY RIGHT TO APPEAL THE DECISION TO THE COURTS.

WE BELIEVE THAT THE EXISTING PART B APPEALS SYSTEM PROVIDES ADEQUATE OPPORTUNITY FOR BENEFICIARIES TO RECEIVE FAIR HEARINGS AND REVIEWS. IT ALSO STRIKES A REASONABLE BALANCE BETWEEN THE COSTS OF HOLDING HEARINGS AND PROTECTING BENEFICIARIES FROM FINANCIAL LOSS. PROGRAM DATA SHOWS THAT OF

THE INITIAL DETERMINATIONS THAT WERE APPEALED TO A REVIEW IN FISCAL YEARS 1982, 1983, AND 1984, NEARLY 60 PERCENT WERE FULLY OR PARTIALLY REVERSED. OF THE REVIEW DETERMINATIONS THAT WERE APPEALED TO A FAIR HEARING OVER 60 PERCENT WERE REVERSED IN WHOLE OR IN PART. THESE RESULTS INDICATE THAT BENEFICIARIES ARE APPEALING IN INSTANCES WHERE THEY BELIEVE THEIR CLAIM HAS MERIT, AND THAT THE CLAIMS ARE RECEIVING FAIR CONSIDERATION. ONE OF THE REASONS FOR THE HIGH REVERSAL RATE IS THAT IN MANY CASES, THE PHYSICIAN DID NOT PROVIDE ENOUGH DOCUMENTATION ON THE SERVICES PROVIDED TO THE BENEFICIARY TO SUBSTANTIATE THE CLAIM. IN MANY CASES, THE CARRIER CONTACTS THE BENEFICIARY'S PHYSICIAN DIRECTLY TO GET FURTHER CLARIFICATION ON A CLAIM. USUALLY WHEN THIS INFORMATION IS PROVIDED THE CLAIM CAN BE SATISFACTORILY SETTLED.

ON A PRACTICAL LEVEL, THESE RESULTS INDICATE THAT A PART B HEARING PROVIDES A FAIR AND IMPARTIAL FORUM FOR THE SETTLEMENT OF DISPUTES INVOLVING CLAIMS OVER WHICH CARRIERS HAVE DIRECT JURISDICTION. MOREOVER, IN THE CASE OF SCHWEIKER V. MCCLURE, (1982) THE SUPREME COURT, IN AN UNANIMOUS DECISION, CONCLUDED THAT THE PART B HEARING PROCEDURES MEET DUE PROCESS REQUIREMENTS.

WE BELIEVE THAT S. 1551 WOULD RESULT IN INCREASED ADMINISTRATIVE COSTS AND ADD TO THE ALREADY LARGE BACKLOG OF CASES FOR BOTH THE SOCIAL SECURITY ADMINISTRATION'S ALJS AND THE FEDERAL COURTS. AS OF AUGUST 1985, THE OFFICE OF HEARINGS AND APPEALS (OHA) HAD A TOTAL OF 107,000 ALJ APPEAL CASES PENDING. IN ADDITION, DUE TO THE RECENT ENACTMENT OF THE "DISABILITY BENEFITS REFORM ACT" (P.L. 98-460), OHA PROJECTS A SIGNIFICANT INCREASE IN THEIR WORKLOAD. FOR FISCAL YEARS 1986 AND 1987 THEY EXPECT A TOTAL OF 311,500 AND 335,000 CASES RESPECTIVELY. THERE ARE CURRENTLY 710 ALJS AND IT TAKES AN AVERAGE OF 160 DAYS TO PROCESS A CASE.

WE ESTIMATE THAT 16,000 PART B CASES WOULD MEET THE $500 AMOUNT TO BE ELIGIBLE FOR APPEAL AT THE ALJ LEVEL. THIS WOULD ADD TO THE ALREADY LARGE BACK LOG OF CASES PENDING IN OHA AND RESULT IN SIGNIFICANT DELAYS FOR BENEFICIARIES IN GETTING DECISIONS ON THEIR CLAIMS. THIS IS PARTICULARLY RELEVENT SINCE THE AVERAGE TIME FOR A CARRIER TO CONDUCT A HEARING IN FY 84 WAS 74 DAYS. WE ESTIMATE THAT THE COST OF IMPLEMENTING THE BILL WOULD RANGE FROM $11 TO $17 MILLION PER YEAR DEPENDING ON HOW MANY CASES ARE APPEALED TO THE ALJ LEVEL. THIS DOES NOT INCLUDE FEDERAL COURT COSTS FOR CASES THAT ARE APPEALED BEYOND THE ALJ LEVEL.

THE BILL WOULD ALSO PROVIDE STATUTORY AUTHORITY FOR MEDICARE PROVIDERS TO REPRESENT BENEFICIARIES IN PART A AND B APPEALS. UNDER CURRENT POLICY, PART A PROVIDERS MAY NOT REPRESENT A BENEFICIARY IN AN APPEAL. WE HAVE PROHIBITED PROVIDER REPRESENTATION IN AN APPEAL BECAUSE WE BELIEVE THAT IN THIS CONTEXT, THE PROVIDERS INTEREST MAY BE DIFFERENT FROM THE BENEFICIARY'S INTEREST AND SIGNIFICANT AMOUNTS OF PAYMENT CAN BE INVOLVED. THIS CAN CREATE CONFLICTS OF INTEREST. THIS IS PARTICULARLY CRITICAL SINCE THE PART A APPEAL PROCEEDING MAY DETERMINE THAT ONE OF THE TWO PARTIES IS RESPONSIBLE FOR PAYMENT.

BECAUSE OF THIS POTENTIAL CONFLICT OF INTEREST, IN JANUARY 1984 WE ISSUED INSTRUCTIONS PROHIBITING A PART A PROVIDER OR ITS EMPLOYEES FROM REPRESENTING A BENEFICIARY IN AN APPEAL. THIS CHANGE IN POLICY WAS A RESULT OF NUMEROUS REPORTS OF PROVIDERS ENCOURAGING BENEFICIARIES TO SIGN HEARING REQUEST FORMS. BENEFICIARIES OFTEN REPORTED LATER THAT THEY DID NOT KNOW WHAT THEY WERE SIGNING AND THAT THEY DID NOT WANT TO APPEAL THE DECISION. WE FOUND THAT IN MANY OF THESE CASES, THE PROVIDER HAD MORE OF A FINANCIAL INTEREST IN AN APPEAL THAN THE BENEFICIARY AND USED THE BENEFICIARY AS AN AVENUE OF APPEAL THAT WAS NOT OTHERWISE AVAILABLE.

CONCLUSION

MR. CHAIRMAN, WE WANT TO ASSURE THAT BENEFICIARIES AND PROVIDERS ARE NOT DENIED THE PAYMENTS THEY ARE ENTITLED TO RECEIVE. WE CLOSELY OVERSEE EACH CARRIER'S OPERATIONS TO SEE THAT THE CARRIER IS PROPERLY AND EFFECTIVELY CARRYING OUT ITS DUTIES IN ACCORDANCE WITH THE PROVISIONS OF THE LAW AND OF ITS CONTRACT WITH THE FEDERAL GOVERNMENT. AS PART OF OUR EFFORTS TO ASSURE THAT THIS IS THE CASE, A SAMPLE OF HEARING TRANSCRIPTS AND DECISIONS, TOGETHER WITH ALL RELATED DOCUMENTS, ARE SENT TO US FOR REVIEW. IN REVIEWING THESE DOCUMENTS WE PAY PARTICULAR ATTENTION TO INSURE THAT THE DECISIONS ARE WITHIN THE LAW, REGULATIONS, AND POLICY GUIDELINES. THE RESULTS OF THESE REVIEWS HAVE CONSISTENTLY SHOWN THAT CARRIER REVIEWS ARE CONDUCTED IN A NON-ADVERSARY AND UNBIASED MANNER. WE BELIEVE THE CURRENT REVIEW AND HEARING PROCEDURES PROVIDE A MEANS FOR PROMPT REDRESS TO BENEFICIARIES, ADEQUATELY PROTECTS THEIR RIGHTS, AND AVOIDS UNWARRANTED ADMINISTRATIVE COSTS.

I WOULD BE PLEASED TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

Senator **Durenberger**. Well, let me begin at the end, then, with a statement that I thought I heard, that said that something or other explains why most of the efforts to expand the appeal process come from providers rather than from beneficiaries.

I know that there are a long list of providers here who want to tell us we have problems, but I guess I don't come to the conclusion that, because we haven't got 30 million people in here today, that means they are not demanding some change.

Can you explain to me where in law the authority lies to deny providers the right to represent beneficiaries in pursuing an appeal under Medicare?

Dr. **Desmarais**. Well, I think we have to go back to the statute which speaks to which appeal rights beneficiaries have versus which rights providers have. And from our way of thinking, that statutory distinction can be blurred if a provider can then assist the beneficiary.

In fact, we have evidence that providers have approached beneficiaries and asked them to sign a form appointing them their representative.

Senator **Durenberger**. Tell me what is wrong with that.

Dr. **Desmarais**. Well, beneficiaries have in fact told us they don't wish to appeal, that they have no interest in appealing, that they were misled in signing the forms. I can read you some of the statements that have been shared with us:

> I did not know what I was signing; they just handed me a paper and told me to sign it. I'm half blind, anyways;
>
> I signed the paper not knowing what it was, due to my sight; however, I do not wish to request a hearing on my home health benefits.

And I could go on and on with those examples. In addition, as I have said, there is a potential conflict, because one of the issues at hand is whether or not the provider or the beneficiary knew that Medicare was not going to cover this service. If the outcome here is that the beneficiary is determined to have known, then it is the beneficiary who is financially liable and not the provider.

Furthermore, in many of these cases Medicare has paid for the claim already under the Waiver of Liability considerations. So, there really is no property interest at stake.

Senator **Durenberger**. I have an interesting view. You don't have a rear-view mirror, but I can sit up here and see some heads are going up and down, some are going like this. [Laughter.]

Dr. **Desmarais**. As long as they are not all going in the same direction.

Senator **Durenberger**. As soon as you get through, I am going to introduce a panel and will have the last member of the panel, as is written, come first. His name is William J. Cox. What he is going to do is read me a bunch of lists that is going to be called the Medicare Appeals Coalition. Maybe he is not going to read the list now. But he is going to read a list that goes like this:

> American Association of Homes for the Aging, American Association of Retired Persons, the Bar Association, the Federation of Home Health Agencies, Health Care Association, Health Care Institute, the Hospital Association, the Medical Association, the Physical Therapy, Providence Hospitals, Speech-Language-and-Hearing, Seatlift Manufacturers, Catholic Health, American Hospitals, Health Industry Distributors Association, Association of Home Care Medical Equipemnt, Private Psychi-

atric, Public Hospitals, Rehabilitation Agencies, Rehabilitation Facilities, Retail Druggists.

And I hear you saying that all those people are out here to rip off the Medicare beneficiaries by putting them through the agony of going through an appeals process so that the providers can make more money than they are entitled to in this system. Now, that is at least one way to hear what you said to me.

Dr. **Desmarais**. No, no.

Senator **Durenberger**. And if that is the position, say it.

Dr. **Desmarais**. No, that is not what I am saying. What I am saying is the claims already have been paid, so that is not the issue. The beneficiary doesn't wish to appeal. The beneficiary has certain appeal rights, the provider has certain appeal rights, and we shouldn't blur those distinctions. And there is the potential for a conflict of interest. Having said all that, we feel it best—and obviously the policy is—to preclude that from occurring; from having the provider represent the beneficiary in those instances.

Obviously, part of the coalition consists of representatives from beneficiary organizations as well. So I don't want to deny that that is true.

When I review the mail that we receive, I believe we have not received a whole lot of beneficiary complaints about the process. There have been some, but there are certainly not overwhelming numbers of complaints.

Senator **Durenberger**. So, when AARP gets here and the National Council of Senior Citizens, that is sort of make-work on their part to be in favor of this? I mean, they didn't have anything to work on today, so they joined the Medicare field's coalition? Or what is it?

Dr. **Desmarais**. No. I certainly don't want to state their case. I think what I have heard is they feel the provider is experienced in dealing with the program, and perhaps that can be of benefit to the individual beneficiary in that instance.

Senator **Durenberger**. I take it that at the heart of the issue of the adequacy of the appeal, the understanding of the issue, really is information. If the beneficiary and the provider have adequate information about how the system operates—not just what their appeal rights are, but just exactly how the reimbursement systems operate—then you can honestly say, "Well, nobody needs any help, because the information enables them to use self-help."

Is there a problem concerning the adequacy of information that is provided beneficiaries, particularly with regard to the part B where there is so much more cost sharing in the process? Do you hear complaints from some of these beneficiaries that they just don't know what they are supposed to be paid, and what qualifies and what is nonqualified, and that they wish they had some process by which they could determine who is ripping them off, if they are being ripped off?

Dr. **Desmarais**. Certainly, information is key. In fact, that is where my statement began, that we need to make every effort to make adequate information available to beneficiaries.

I think our process has improved. We have improved the readability of some of the notices we were giving the beneficiaries, because there were court cases that suggested they couldn't read what we were sending them—for example, in the "Explanation of Medicare Benefits," which is really the part B side, they didn't understand that. Those forms certainly have been improved now to where they are readable. They provide information. At the top it says, "If you need help, call" so-and-so "at this number." And I think every attempt has been made to really improve that process. It wasn't the best process; I think it has gotten better over time.

We are also working more on additional pamphlets to make available to beneficiaries. We have had some problems with prospective payment, in that there are certain myths that have grown up which have confused beneficiaries. I think we are doing what we can to dispel them. I think we need to commend organizations like the AARP that are doing a lot in their own right. They have prepared a publication that elaborates upon appeal rights, what is prospective payment, what are PRO's, what is this all about, what do you, the beneficiary, need to know?

I think more can be done, and we are trying to do more.

Senator DURENBERGER. Is your position that we don't need to change the process of adjudicating financial outcomes with regard to part B? That it works just fine the way it is now?

Dr. DESMARAIS. Well, as I said, given the magnitude of the number of claims and the outcome of the current process, where there is a fair amount of reversal, we believe the system is wrong. I mean, the allegation has been, "Well, they are biased." Well, if they are so biased, why did they reverse themselves 57 percent of the time at the reconsideration level, and 62 percent of the time at the fair-hearing level? It defies my understanding of how they could be so biased. One would expect a rubberstamp if they were in fact biased.

I think the program's instructions try to assure that there is no conflict of interest, that the adjudicating officer gives a new, fresh look at the situation.

As I said earlier, one of the outcomes of this process is frequently information that really is needed to come to a coverage determination that just wasn't available when the claim was sent in. So, the claim is perfected and the proper outcome is reached.

Senator DURENBERGER. Well, I regret we don't have more time today to go into the issue. I thank you for your testimony, and I am going to have to submit all of the other questions to you in writing.

Thank you very much.

Dr. DESMARAIS. Thank you, Mr. Chairman.

[The questions follow:]

Senator DURENBERGER. All right. We next have a panel of William J. Cox, vice president, the Catholic Health Association; Linda Billows, administrator of Visiting Nurses Association of Greater Salem, MA, on behalf of the National Association for Home Care; Jack Owen, executive vice president of the American Hospital Association; Robert Stutz, vice president and general director, Willowcrest-Bamberger Division of the Albert Einstein Medical Center in Philadelphia, on behalf of the American Association of Homes for the Aging; and Frances Steele, executive director of the Home Health Agency Multicounty, Hattiesburg, MS, on behalf of the American Federation of Home Health Agencies, Inc.

All of your statements will be made part of the record. You may summarize them in 5 minutes or less—we give points for less—and we will start with Bill Cox, who has already been saved some time by my reading his petition.

Mr. Cox. And that statement will be made part of the record, Mr. Chairman?

Senator Durenberger. Yes.

STATEMENT OF WILLIAM J. COX, VICE PRESIDENT, GOVERNMENT SERVICES, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, WASHINGTON, DC

Mr. Cox. Mr. Chairman, we are here this morning essentially to discuss the need to improve due process for providers and beneficiaries in the context of the Medicare Program.

I would like to cite a few examples which dramatically highlight and underline the pressing need for reform in this area. Consider the following:

Mrs. Jones, a Medicare beneficiary, is unhappy with the amount of reimbursement she received from the Medicare Program for her recent doctor bills while she was in the hospital. The Medicare carrier gives her a hearing and makes a slight adjustment to the payment. Still, she is out-of-pocket several hundred dollars. She wonders what else she can do to appeal her decision. She is told she can do nothing.

Mr. Smith is also a Medicare beneficiary. Pursuant to his doctor's orders, he purchases a certain kind of hospital bed. The Medicare carrier denies the claim because it is not on the Medicare-approved list of hospital beds. He asks the carrier to reconsider but is told he would be wasting his time because there is nothing the carrier can do, it is "bound by HCFA's instructions." He is also told he has no further right of appeal.

A hospital submits a claim for a pulmonary embolism with a secondary diagnosis of phlebitis. The peer review organization, upon retrospective review, decides the case is really phlebitis with a secondary diagnosis of pulmonary embolism. That decision reduces the hospital's payment for that case by about $1,500. The hospital asks for a reconsideration; the reconsideration is done by a pediatrician and the PRO who upholds the original decision. The hospital has no further remedy, neither does the beneficiary, since HCFA regulations give no appeal rights to beneficiaries in cases involving DRG validation.

Mr. White also has his home health care claim denied by Medicare on the grounds that he was not homebound. The home health agency wishes to appeal this decision, but is told it has no right to do so, nor may it represent Mr. White, who cannot afford the attorney fees nor represent himself, since he is in fact a shutin. The home health agency would have handled his case for free.

Under pressure to further reduce the deficit, the Health Care Financing Administration, without any advance notice, publishes an emergency regulation cutting the basic Federal rates under the prospective payment system across the board by more than 4½ percent. The regulation is effective immediately. Outraged by this act, a hospital files suit in Federal court the next day. The court throws the case out because it lacks jurisdiction. The hospital is told it must wait a couple of years until it receives the proper forms and documents from its intermediary before it can then take its case to the Provider Reimbursement Review Board, an administrative tribunal which has no power to overturn the regulation, anyway.

Although these hypotheticals may seem outrageous, they are all possible results under the current Medicare statute. Indeed, you will hear during the course of the testimony this morning real life stories that are no less shocking.

The time has come for meaningful change. S. 1551, Mr. Chairman, will correct two of the problems that have been mentioned; but, as earlier examples illustrate, there are several other areas where the Medicare statute is deficient in terms of ensuring access to due process.

One is in the area of PRO appeals for providers. Another is in the area of reforming the Administrative Procedures Act requiring the Medicare Program, for the first time in its history, to follow the requirements of the Administrative Procedures Act, which law has not been amended since 1948.

In summary, all that the Catholic Health Association seeks is a measure of fairness by restoring some balance to the Medicare Program.

As I noted earlier, in introducing, S. 1551, Mr. Chairman, you described the appeals process as a "stacked deck." The Catholic Health Association heartily agrees with that statement.

That concludes my testimony, Mr. Chairman.

Senator **Durenberger**. All right, thank you very much.

Ms. Billows.

[Mr. Cox's written testimony follows:]

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STATEMENT
of the
CATHOLIC HEALTH ASSOCIATION
of the
UNITED STATES

on

MEDICARE APPEALS PROCEDURES

Presented to
The Subcommittee on Health,
Committee on Finance
United States Senate

by
William J. Cox
Vice President
Division of Government Services

November 1, 1985

Representing almost 900 hospitals and long-term care facilities nationwide.

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STATEMENT FOR THE RECORD

Mr. Chairman and members of the subcommittee, my name is William Cox. I am Vice-President for Government Services for the Catholic Health Association of the United States (CHA). I am pleased to be here today to share with you our thoughts and comments on this most vital topic.

CHA is seriously concerned with what it believes to be the stacked deck nature of the current appeals process under Medicare law. Attached as an exhibit to this statement is an analysis of the existing Medicare appeal rights and procedures which was prepared for CHA by the national health care law firm of Wood, Lucksinger & Epstein. This analysis confirms that the current system of review is filled with insurmountable hurdles, procedural deadends and fundamental unfairness. The analysis also suggests several actions Congress could take immediately to improve Medicare appeals procedures for both providers and beneficiaries.

At the outset, I commend you, Mr. Chairman, as well as Senators Heinz and Chafee, for introducing S.1551, the "Fair Medicare Appeals Act of 1985." The bill would correct two of the more fundamental problems which currently exist.

The bill would create for the first time a true appeals process for beneficiaries under Part B of the Medicare program. Currently, beneficiaries can only obtain what Sen. Heinz has aptly described as an "in-house paper review or hearing by the same institution which made the original decision." While such a process may have been adequate twenty years ago, it clearly no longer is. Part B claims can run into thousands of dollars, especially now that more procedures are being done on a outpatient basis.

The other deficiency which the bill would correct would be to reinstate the right of a beneficiary to appoint the provider as his or her representative in pursuing an appeal.

Beneficiaries may be represented in Part A appeals or Part B fair hearings. Representatives need not be lawyers, and often are not lawyers. Historically, providers would often appear as the beneficiary's selected representative. Suddenly, with no notice or opportunity for comment, HCFA took away this right of a beneficiary through a Manual instruction in January 1984. The ostensible basis for HCFA's new policy -- that providers inherently have a conflict of interest with beneficiaries -- is entirely bogus. In point of fact, there is virtually never a situation where a conflict exists. This is borne out by the fact that in the eighteen years that such representation was allowed, none of the major beneficiary groups can recall a single complaint or documented instance of abuse. In short, HCFA's action in this regard is an outrage and should be reversed.

Besides the two specific matters which are addressed by S.1551, there are several other problems which CHA believes are equally important and should also be corrected legislatively by the Congress. I will briefly describe them here. (Once again, I would refer you to the attached exhibit for a more detailed analysis of the problem and CHA's recommendations for appropriate changes in existing law.)

First, CHA strongly believes that the time has come to make it clear, by statute, that Medicare regulations promulgated by the Department of Health and Human Services should be subject to the Administrative Procedures Act ("APA"). While the Department has voluntarily complied with this law for a number of years, it is not obligated to do so. Indeed, the Secretary, in a proposed regulation published on June 22, 1982, tried to limit dramatically the extent to which programs such as Medicare would comply with the APA's notice and comment requirement. The preamble to that proposed rule is particularly instructive because it indicates the Department's true attitude. For example, it states that the Department does "not believe . . . that it is appropriate for the Department to be held to the rigorous standard" found in the APA. Further, they also make it clear that "the Department's voluntary use of notice and comment procedures is not intended to create any judicially enforceable rights" (emphasis added). In short, the Department is of the opinion that it could, if it wanted to do so, publish a new regulation without any advance warning and no one could object in court. The CHA believes that this is completely contrary to the American way of justice.

Unfortunately, the lack of judicial remedy does not stop with just the Administrative Procedures Act either. If a beneficiary or health care provider believes that a Medicare regulation or policy is wrong, there is very little that can be done about it on a timely basis. For example, in 1979 the Department promulgated a regulation concerning reimbursement to providers for malpractice costs. Without debating the merits of that issue, we wish to point out that the controversy is still not settled some six years later! We think that is ridiculous.

The lack of timely review is made even more problematic by the enactment of the prospective payment system ("PPS"). It is not our intent here to challenge the Congressional prohibition against appealing certain aspects of PPS. Rather, our concern lies with those things that are appealable under PPS. Under HCFA's regulation, it is probable that a hospital could successfully challenge an intermediary's determination of its hospital-specific rate and yet never receive one penny in additional reimbursement. This is because it takes so long before a hospital is even allowed to begin the appeals process that the three years of transition will have ended before the dispute is resolved. This is patently unfair and, I have no doubt, not what Congress intended.

I would urge, therefore, that Congress enact legislation to make it clear that the Medicare rulemaking process is subject to the Administrative Procedures Act and that any new policy not implemented in accordance with the APA is not binding on Administrative Law Judges, the Provider

Reimbursement Review Board, carriers, intermediaries and peer review organizations. We also strongly support enactment of a provision that would allow direct and immediate access to the courts to challenge the final rule of the Secretary. Without these procedural safeguards, providers and beneficiaries alike are at the mercy of bureaucrats, who will act according to their own capricious whims, secure in the knowledge that their actions cannot be effectively challenged.

Finally, under the current law for peer review organization ("PRO") decisions, providers have no remedy to challenge an adverse decision of a PRO. Only the reconsideration process is allowed. Thus, the provider may only ask the entity which made a negative decision in the first place to change its mind. A beneficiary may appeal, but almost never has a reason to do so. It is ironic indeed that the party with the least at stake may appeal, but the one with the most at stake may not.

Stories are beginning to appear in the media about arbitrary actions and decisions by PROs. More such stories are sure to follow, particularly if HCFA follows through on its announced intention to abolish a hospital's favorable presumption under waiver of liability. Yet there is no effective mechanism to hold the PRO accountable for its decisions.

CHA therefore also seeks passage of an amendment to the existing PRO law to allow providers and practitioners to appeal final adverse PRO determinations not paid under waiver. Enactment of such an amendment will in no way undermine the important function a PRO performs. In fact, CHA believes it will strengthen it. This is because many of the hard decisions a PRO must make will be validated by an independent authority, while at the same time affording an additional measure of protection to those who believe, rightly or wrongly, that they have been the victim of a bad decision. In short, it would add some additional credibility to the program.

In summary, what CHA is advocating is fundamental fairness. The ability to obtain redress of grievances is a basic tenet of American democracy. So is the concept of checks and balances. Right now the Medicare program is out of balance. Enhanced access to a meaningful appeals process, including the judicial branch of government, will help restore that balance. It will also bring an added measure of accountability to those in and out of government who make critical decisions which directly affect the health care of millions of Americans. You in Congress, Mr. Chairman, have the ability to act on these urgent matters. We strongly urge you to do so without delay.

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MEMORANDUM

TO: Catholic Health Association

FROM: Wood, Lucksinger & Epstein

RE: Medicare Appeal Procedures

DATE: October 23, 1985

Introduction

Providers and beneficiaries participating in the Medicare program inevitably encounter conflicts with those administering the program. Such conflicts can potentially arise with respect to a providers participation in the program, program payments, coverage decisions, or the application of new Medicare rules and regulations. While there has been some statutory recognition of the need to provide mechanisms for the resolution of such conflicts, in other areas providers are given little recourse once an administrative decision has been reached.

The following is an analysis of the various points in a provider's participation in the Medicare program at which conflicts with those administering the program might arise. In describing each potential area of conflict, there is a description and analysis of the applicable appeals process, if any. The various areas of potential conflict are classified into five categories: (1) conditions of participation; (2) provider reimbursement disputes; (3) coverage disputes, (4) Part B disputes and (5) challenges to final regulations issued by the Department of Health and Human Services ("HHS"). Within each category are listed those specific issues which might give rise to conflicts along with an analysis of the existing appeals procedures and the proposed means for addressing their deficiencies.

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I. Conditions of Participation

1.1 Appealing Initial Determinations

Hospitals wishing to participate in the Medicare program must satisfy the Conditions of Participation established by the Health Care Financing Administration ("HCFA") (although hospitals accredited by the Joint Commission on Accreditation of Hospitals ("JCAH") or by the American Osteopathic Association ("AOA") are deemed to have met most Conditions of Participation). If a hospital is dissatisfied with an initial determination concerning its eligibility to participate or continue participating in the Medicare program because of an alleged failure to comply with the Conditions of Participation, it may request a reconsideration of that determination. 42 C.F.R. § 405.1510. If the provider is dissatisfied with HCFA's reconsideration determination, it may then seek a hearing before an Administrative Law Judge ("ALJ"). 42 U.S.C. § 1395ff, 42 C.F.R. § 405.1530. An adverse decision to the hospital at this level may be appealed by it to the Appeals Council of the Social Security Administration, 42 C.F.R. § 405.1561, and ultimately to a federal district court. 42 C.F.R. § 405.1567.

While an initial determination regarding a provider's eligibility to participate in the Medicare program is subject to several levels of review, these appeal rights come too late for providers terminated from the program. Once HCFA has decided to terminate a provider's participation agreement, which may result from an alleged violation of the Conditions of Participation or the participation agreement itself, the provider is given fifteen (15) days notice before the effective date of the termination. From that effective date forward, the Medicare program will not provide any reimbursement for services rendered to Medicare patients (except that payments may be made for up to 30 days for inpatient hospital services provided to patients admitted before the effective date of the termination).

Despite the often devastating impact of a termination decision, given that the average hospital Medicare utilization rate is between 35-40%, providers are not given pre-termination hearings. In the case of O'Bannon v. Town Court Nursing Center, et al., 447 U.S. 773, 100 S.Ct. 2467, 65 L.Ed.2d 506 (1980) the Supreme Court held that this appeals procedure, which denies providers evidentiary hearings until after termination decisions have become effective, meets the minimum requirements of due process; however, as a practical matter, few providers can pursue appeals when the effect of the agency action is to drive them out of business. While providers may appeal termination decisions through the same process established for the appeal of an initial determination regarding program participation, the termination decision is not stayed pending the outcome of this appeals process. Providers may therefore suffer irreparable harm while awaiting the outcome of an appeal of a termination decision.

While it might be argued in theory that the Conditions of Participation with which providers must comply are objective in nature and that a termination decision will likewise involve little subjectivity, in practice this is almost never the case. Further, a Provider Agreement may be terminated for reasons other than deviations from the Conditions of Participation[1], many of which clearly involve subjective judgments. Consequently, the fact that providers are not given pre-termination hearings essentially gives HCFA carte blanche to terminate providers whenever it perceives a violation of a Provider Agreement or detects any cause for termination as set out at 42 C.F.R. § 489.53.[2]

Given the present regulatory scheme governing provider appeals of initial determinations, HCFA would have to amend its regulations in order to provide for pre-termination hearings. In view of the fact that the present appeals process has been found to meet the minimum requirements of due process, it is unlikely that HCFA would take the initiative to promulgate such an amendment. It is therefore likely that such action would require legislative intervention.

1/ Pursuant to 42 C.F.R. § 489.21 any hospital whose Medicare inpatient has been billed improperly in violation of the prohibition on "unbundling," even by an entity unrelated to the hospital, and even if the hospital had no knowledge of the billing, is deemed to have violated its Medicare Provider Agreement and could be terminated from the Program.

2/ While one would assume that retroactive relief would be available to a provider upon the reversal of a termination decision on appeal, such relief cannot be assumed as it is not mentioned in the regulations granting providers their appeal rights. Concern over the availability of retroactive relief is particularly relevant in light of HCFA's present fixation on prospectivity. See Section 2.2-1 below.

1.2 Other Status Determinations

While provisions have been made for appealing determinations regarding a provider's initial and continuing participation in the Medicare program, the appeal rights of providers are somewhat less certain with respect to some other types of "status" determinations which are becoming increasingly important to providers.

Foremost among these status determinations in whether or not an outpatient department is deemed part of a hospital for Medicare reimbursement purposes or whether it will be considered a physician-directed clinic. The central issue in such a determination is whether or not the department is an "integral part" of the hospital. Among those factors considered in making this subjective determination are: licensure, Hospital by-laws and Articles of Incorporation, JCAH accreditation, medical staff by-laws, medical records, billing, physical layout, financial arrangements with physicians and staffing. In light of the financial impact an intermediary's determination in this regard can have on a hospital, it is difficult to believe that there are no specific provisions for providers wishing to appeal such determinations. While it is arguable that the reimbursement consequences of such determinations would be appealable to the PRRB pursuant to 42 U.S.C. § 1395oo,[3] there are no specific statutory or regulatory provisions for appealing the underlying status determination.

Another status determination which has gained importance over the past several years relates to swing-bed approvals. Pursuant to § 1883(a)(1) of the Social Security Act, a rural hospital with less than 50 beds which has a Medicare provider agreement can enter into an agreement with the Secretary to provide skilled nursing care within its inpatient facility. While it was Congress' intent that the procedures concerning the withdrawal of swing-bed approval parallel the procedures concerning termination of skilled nursing facility provider agreements, there are no specific regulations governing the appeal rights of providers wishing to appeal terminations of swing-bed agreements. A provider might argue that in the absence of a regulation providing for a different termination procedure, the procedure applicable to the termination of a skilled nursing facility's provider agreement, which includes the right to a hearing before an ALJ, would apply, HHS could counter by stating that it would have amended the applicable regulation had this been its intent. To date, HHS' practice has been to inform providers of a right to a hearing before an

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[3] The difficulty with this argument is that the dispute in not one over reimbursement *per se*.

ALJ upon termination of a swing-bed agreement. But so long as there is no statutory or regulatory authority for this hearing, the possibility will always exist that HHS will simply take this right away, rendering uncertain the appeal rights of affected providers.

As the various status determinations rendered by HCFA and the fiscal intermediaries for the Medicare program increase in importance, so too will the need for an effective appeals process. While HCFA has afforded appeal rights to providers with respect to some of these determinations, the need exists for statutory and/or regulatory authority for these rights so that providers can rely upon them with confidence. Such action may be taken by HCFA on its own initiative through its rulemaking procedures or by Congress in the form of new legislation.

II. Reimbursement Disputes

2.1 Cost Reimbursement Issues

While the implementation of the Prospective Payment System ("PPS") in 1983 has mooted or rendered immaterial many of the traditional cost-based reimbursement disputes, several important items of service continue to be reimbursed on the basis of cost, at least for the time being. Such items include expenditures for capital, direct medical education, outpatient hospital services (Part B), services in excluded hospitals and units, skilled nursing facility services, home health services, comprehensive outpatient rehabilitation facility services, Medicare bad debts, services rendered by certified registered nurse anesthetists, and inpatient care provided to beneficiaries who have exhausted their Part A coverage. All of the issues relating to what is and what is not an allowable cost, which have existed since the inception of the Medicare program in 1966, will continue to pertain to these provider services for so long as they are reimbursed on a cost basis. Additionally, many cost reimbursement disputes are still in the "pipeline" from pre-PPS years with an estimated 2,000 cases still pending at the Provider Reimbursement Review Board (hereinafter "PRRB" or "Board").

2.1-1 Deficiencies in the Statutory Appeals Process

With respect to reasonable cost disputes, a provider may challenge adverse determinations made by its intermediary. The appeals process established for pursuing such a challenge is codified at 42 U.S.C. § 1395oo. The statute provides that a hospital participating in the Medicare Program is entitled to a hearing before the PRRB if it is dissatisfied with the final determination of its fiscal intermediary as to the amount of total program reimbursement due the hospital for the cost reporting period at issue. In order to qualify for a PRRB hearing, the provider must have at least $10,000 in controversy. If an appeal is pursued by a group of providers sharing a common question of fact or interpretation of law or regulation, the aggregate amount in controversy must be at least $50,000. In addition to providing for a hearing before the PRRB, the statute also provides for judicial review should the provider disagree with the findings of the Board.

There are several practical problems with the PRRB appeals process. One of the most significant practical drawbacks to the appeals process is the requirement that a Notice of Program Reimbursement ("NPR") be issued before an appeal can be filed with the PRRB.[4/] Given that NPRs are generally not issued for at least a year after the close of a given cost reporting period, it can take several years for an appeal to be heard by the Board. The following table illustrates the time frame involved in the pursuit of a PRRB determination. It should be noted that an intermediary will begin making interim

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[4/] While 42 C.F.R. § 405.1835(c) provides that an appeal may be taken before an NPR has been issued if an intermediary's determination concerning the amount of reimbursement due a provider is not issued within one year after receipt by the intermediary of a provider's perfected cost report or amended cost report, the Board has abrogated this right by simply taking jurisdiction in such cases and sending a letter to the intermediary asking it to settle the cost report and issue an NPR.

payment adjustments within 90 days of the start of a cost reporting period which means a provider can be denied its due for up to four years or more from the time funds are initially withheld.

Event	Elapsed Time
Cost reporting period begins	
Interim payment affected	90 days
Cost reporting period ends	1 year
Cost report filed by provider[5]	1 year, 4 months
Cost report settled by intermediary and Notice of Program Reimbursement issued	2 years, 4 months
PRRB decision	4 years

While the NPR requirement has always created problems of delay for providers, this problem has become even more acute with the implementation of the PPS. The implications of the NPR requirement on PPS reimbursement will be discussed later in this section.

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[5] In addition, the above chart assumes that the cost report form itself is immediately available to the provider at the end of the reporting period. This has not been the case in recent years. For example, HCFA Form 2552-84, the cost report for a hospital's first year under PPS, was not available until the Spring of 1985, a full six months after some providers had completed their fiscal year.

While the statute governing reimbursement appeals does not specifically refer to an NPR, it does require a final determination as to the total program reimbursement due a provider before an appeal may be pursued. While such a determination is a logical prerequisite to the pursuit of a reimbursement appeal, there is no justification for the lengthy delays in issuing these determinations. A practical solution to this problem would be to call upon HCFA to meet with the intermediaries and insist on the development of a more timely method for issuing final determinations to providers. Alternatively, providers could seek legislation that would impose strict time limitations on intermediaries in the issuance of their final determinations (shorter than the one year limitation presently in the statute).

Another practical concern of providers pursuing PRRB appeals is that of the Board's lack of independence from HCFA. First of all, Board members are appointed for a three year term by the Secretary of HHS. Furthermore, while 42 U.S.C. § 1395oo(h) provides that "all members of the Board shall be persons knowledgeable in the field of payment of providers of services," it is noteworthy that the Secretary has repeatedly appointed Board members who have no familiarity with hospital finance and/or accounting. More importantly, however, is the "own motion" review authority afforded the Secretary. Pursuant to 42 U.S.C. § 1395oo(f)(1)(a) the Secretary, on her own motion and within sixty days from the time a provider is notified of the Board's decision, may reverse, affirm or modify that decision. While the statute clearly indicates that the Secretary may overrule PRRB decisions, it also contemplates that the Board will be of sufficient competence and stature as to render such administrative reviews unnecessary in all but exceptional circumstances. Such has not been the case over the past several years however, as the Secretary, through the Deputy Administrator of HCFA, has vigorously exercised her prerogative to reverse PRRB decisions rendered in favor of health care providers. Hence, in addition to the delay in filing PRRB appeals resulting from the NPR requirement, the Secretary's "own motion" review of Board decisions serves to further delay any final review and resolution of a provider's appeal by a court of law since a final decision by the Secretary is necessary before a provider may pursue judicial review. While legislative action would be required to amend 42 U.S.C. § 1395oo(f) so as to statutorily eliminate or modify the Secretary's "own motion" review authority, the Secretary could take the initiative in limiting the circumstances under which PRRB decisions may be disturbed by the Deputy Administrator of HCFA. Such limitations could be imposed through the promulgation of regulations which would be binding on the Deputy Administrator. Alternatively, the scope of the "delegation of authority" from the Secretary to the Deputy

Administrator could be modified to impose appropriate limits on the review.

Another practical flaw in the PRRB appeals process relates to the requirements established for the filing of group appeals, otherwise known as the Common Issue Related Party ("CIRP") rule. Pursuant to Section 1878(f)(1) of the Social Security Act, as amended on April 20, 1983, hospitals under common ownership or control are now required to bring their appeals on common issues filed after that date as a group. This requirement was apparently enacted at HCFA's request in order to reduce what it perceived to be forum shopping or attempts by multi-hospital systems to litigate the same issue in numerous jurisdictions. What these providers were actually doing was preserving their right to appeal to the federal district court in their own home district rather than the District of Columbia. According to the venue rules in effect at the time, providers had to either appeal in the district in which they were located or in the District of Columbia. When providers became members of multi-state group appeals, it became unclear where the proper venue for an appeal of an adverse PRRB decision would lie and providers became legitimately concerned about losing the right to judicial review in the district in which at least some were located. The venue rules have been changed however, and appeals may now be brought in the District of Columbia or in the district in which most of the providers are located. 42 U.S.C. § 1395oo(f)(1). This change has eliminated the incentive among multi-hospital providers to pursue numerous splinter appeals on the same issue, thereby eliminating the problem which the CIRP rule was designed to address.

The first and most troubling of the problems created by the CIRP rule is the potential that a provider could be foreclosed from appealing a particular issue solely because it was unaware of an appeal brought by a related provider for a cost reporting period ending in the same calendar year. This problem is particularly acute for the various Catholic hospitals which, while technically related by virtue of their connection to their respective Orders, are generally not coordinated and act totally autonomously. While the issue of relatedness, which is a question of fact, never had to be dealt with before, the CIRP rule has suddenly made this elusive concept central to a provider's appeal rights.

Problems have also arisen as a result of the Board's interpretation of the CIRP rule that unrelated hospitals are precluded from participating in group appeals brought by related hospitals. This interpretation has forced existing group appeals to split up into smaller groups, thereby creating terrible confusion since the various providers inevitably have different attorneys, accountants and intermediaries involved in their appeals. Aside from the confusion created, this interpretation of the CIRP rule seems to frustrate the intent of Congress which was, at least in part, to limit the number of separate, possibly conflicting, judicial decisions on a particular issue.

In addition, there are needless delays resulting from the requirement that NPRs be issued for all group members before an appeal can proceed and the Board's interpretation of the rule as requiring that each calendar year within a group appeal be separated out for purposes of calculating the amount in controversy. This interpretation has essentially reversed the Fourth Circuit's decision in Cleveland Memorial Hospital, Inc. v. Califano, 594 F.2d 993 (1979), in which the Court specifically held that claims from various years may be aggregated by providers to meet the amount in controversy requirement. Finally, the CIRP rule is silent on the issue of how to handle a case in which judicial review has been initiated after April 20, 1983, on an appeal filed before that date. Hence, the CIRP rule has caused many more problems than it has solved.

Given that the CIRP rule is a creature of statute, its repeal would require legislative action. Such action would be most appropriate in view of the fact that Congress' intent to limit the number of separate, potentially conflicting judicial decisions on a particular issue has been frustrated rather than furthered by the implementation of the rule.

2.1-2 HHS' Non-Acquiescence Policy

In addition to the practical deficiencies of the PRRB appeals process, HHS has also created its own obstacles for providers pursuing their statutory appeal rights. HHS' policy of non-acquiescence is one example of the obstructive posture the Department has taken in relation to all Social Security appeals, including Medicare. The policy of non-acquiescence, which has been applied with greatest publicity in cases involving disability payments, provides that the agency, following a court decision in a particular case, may ignore that ruling as it might apply to all other similar claims within that federal circuit.[6] Consequently each succeeding claimant in that circuit would be required to exhaust all administrative remedies and pursue their claim through the federal courts even though the claimant's position may be consistent with an earlier decision of the federal court of appeals within that circuit. This policy of non-acquiescence is very different from that adopted by the Internal Revenue Service, which after losing a case in a particular circuit will decide whether or not it will acquiesce. If it decides to acquiesce, it will adopt the court's decision on a national basis. If it chooses not to acquiesce, it will not adopt the decision nationally but (unlike HHS' posture) will abide by the decision in the circuit in which it was rendered.

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[6] An example of HHS' non-acquiescence policy appears in the case of Jones v. Califano, 576 F.2d 12 (2d Cir. 1978). In that case, the Court stated that HHS' refusal to follow the rulings of the Appeals Council of the Social Security Administration thereby forcing claimants to exhaust their administrative remedies on an individual basis only to receive a judgment which was a foregone conclusion from the start "raises colorable questions of equal protection and due process." 576 F.2d at 18.

While HHS has modified its policy of non-acquiescence in response to Congressional concern and criticism, the modified policy continues the practice within the preliminary administrative process and only requires judicial precedent to be considered if a claim is brought before an ALJ. At that stage in the proceeding, the ALJ would make a recommendation to the Social Security Appeals Council as to whether or not the judicial precedent in the circuit should be followed. The Appeals Council is then free to follow or disregard this recommendation. (Given that provider reimbursement appeals are not processed in this manner, the modification of the policy will have no affect on these appeals.) Hence even in its modified form, the policy of non-acquiescence reserves to HHS the right to disregard the law. In his opening statement at a June 25 Hearing on the policy of non-acquiescence convened by the Judiciary Subcommittee on Administrative Law and Government Relations, Congressman Dan Glickman referred to the policy of non-acquiescence as "a policy to operate outside the law." While witnesses for the government suggested that the policy had been established in the interests of departmental flexibility and national uniformity, Professor Lea Brilmayer responded to these arguments by stating that HHS' goal was not uniformity but rather "minimizing the number of cases in which benefits must be paid."

HHS has exhibited similar disregard for precedent in opposing providers that have sought judicial review of claims for Medicare reimbursement. HHS' handling of the case of St. Mary of Nazareth Hospital v. Heckler, 80-3280, (D.D.C. June 29, 1984), aff'd, 760 F.2d 1311 (D.C. Cir. 1983), is a good example of the obstructive posture it has taken in cases where Medicare reimbursement policies have been subject to provider challenges.

The central issue in St. Mary was the validity of HCFA's labor room day policy, implemented in 1976. As implemented, that policy served to understate a provider's Medicare utilization, thereby reducing its Medicare reimbursement. Upon receipt of their NPRs for fiscal year 1977, the first year during which they were affected by the new labor room day policy, the providers in St. Mary appealed the labor room day issue to the PRRB, which ruled in their favor in a decision dated August 19, 1980. The Deputy Administrator of HCFA then elected to review the PRRB's decision and reversed it by a decision dated October 17, 1980. Dissatisfied with the Deputy

Administrator's reversal, the providers then sought judicial review of this determination.[7] For those hospitals involved in this original appeal, the District Court affirmed the Deputy Administrator's decision in the case of St. Mary of Nazareth Hospital Center v. Schweiker, 80-3280, 81-0396, 81-0994 (D.D.C. November 9, 1981). However, on September 23, 1983, in a strongly worded decision, the United States Court of Appeals for the District of Columbia reversed the District Court and concluded that the labor room day policy was arbitrary, capricious and a violation of the Medicare Act. Since HHS indicated that its policy could be justified by other costs incurred by the Program, the Court remanded the case to the District Court giving the government an opportunity to add evidence to the record to support this argument. On November 7, 1983, HHS filed a Petition for Rehearing and Petition for a Rehearing en banc, both of which were denied. In those petitions, HHS conceded that it had no factual evidence to support its argument that other costs incurred by the program would justify the labor room day policy.

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[7] The American Hospital Association, which coordinated this group appeal, purposely filed suit in the District of Columbia, which is the federal district to which all providers have a right of appeal, as it hoped this would result in a final nationwide resolution of the labor room day issue.

In the course of the numerous status hearings held in an attempt to resolve disagreements which arose with respect to the Court of Appeal's remand order, HHS ultimately presented a new theory to support its labor room day policy and argued that it should be permitted to present this evidence pursuant to the remand order issued by the Court of Appeals. After a number of hearings and exhaustive briefings, the District Court finally ordered HHS to comply with the clear language of the remand order issued by the Court of Appeals. In August of 1984, HHS filed an appeal of this decision. By this point in time, those hospitals that participated in the original St. Mary appeal had been litigating their case with HHS for more than 5 years. In appealing the District Court's interpretation of the Court of Appeal's remand, HHS was also able to temporarily deny hospitals in other cases the favorable precedent established in St. Mary.

Despite all the delay, on April 30, 1985, the Court of Appeals ruled as a matter of law that the labor room day policy was arbitrary, capricious and a violation of the Medicare Act and that it could not be justified by any of the evidence proffered by HHS. The St. Mary providers did not actually begin receiving the reimbursement they had been denied for nine years as result of the labor room day policy until the end of September and only received reimbursement for the fiscal year which had been appealed. Given that HHS did not seek Supreme

Court review of this decision along with the fact that all providers have a statutory right to appeal to the District Court for the District of Columbia, this decision indeed represents the law of the land with respect to the labor room day policy. Notwithstanding the logic in this conclusion, HHS has refused to acquiesce in the final ruling in St. Mary and continues to remand favorable PRRB decisions back to the Board for the consideration of evidence which the Court of Appeals has already concluded is insufficient to justify the labor room day policy. While HHS might have a number of justifications for its current handling of labor room day appeals, as Professor Brilmayer suggested in his testimony before the House Judiciary Committee Hearing on the non-acquiescence policy, the primary goal of such action appears to be nothing more than that of minimizing the number of cases in which the government must ultimately make payments.

In light of HHS' continued commitment to its non-acquiescence policy, as evidenced by its current position with respect to the labor room day issue, it is very unlikely that it will independently alter its position on this issue. Providers must therefore enlist the support of Congress and seek legislation that would bind HHS to legal precedents established within the various federal circuits.

2.2 Prospective Payment Determinations

It is clear from the statute enacting PPS that some thought was given to the ramifications of the appeals process on a system of prospective payment since more than technical changes were made in the basic provisions governing the appeals process under the Medicare program. Congress apparently felt that PPS could be undermined if hospitals were permitted to appeal some of the very basic issues. Thus, while 42 U.S.C. § 1395oo(a) provides for the review of final determinations made by fiscal intermediaries, with regard to the amount of reimbursement due a provider, § 1395oo(g) specifically states that "determinations and other decisions described in Section 1886(d)(7) of the Social Security Act shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise." The decisions and determinations described in Section 1886(d)(7), which are not appealable, are those relating to budget neutrality, the establishment of DRGs, the methodology for the classification of DRGs, and the weighting factor assigned to DRGs. At the same time, however, Congress expressly made everything else appealable, subject only to existing constraints. This would seem to be apparent from the following paragraph in the Report of the House Committee on Ways and Means on Title VI of H.R. 1900 (H.R. Rept. No. 98-25, pg. 143):

> Your Committee's bill would provide for the same procedures for administrative and judicial review of payments under the prospective system as is currently provided for cost-based payments. In general, the same

> conditions, which now apply for review by the PRRB and the courts, would continue to apply.

While the reimbursement methodology of the prospective payment system tends to eliminate many of the traditional cost-based reimbursement issues, such disputes will continue to arise with respect to those items of service which will continue to reimbursed on a cost-basis. In addition to the listing provided earlier of those items which will continue to be cost reimbursed, a major focus for PPS purposes is and will be on appeals of base year costs which are used in calculating the hospital-specific portion ("HSP") of each hospital's PPS rate. 8/ Any appeal taken with respect to these base year costs will have a five year effect on payment -- the base year, the TEFRA target rate year and the three years of transition under PPS.

8/ Each hospital's HSP is calculated on the basis of the allowable costs incurred in its base year, which was its cost reporting period beginning on or after October 1, 1981 and on or before September 30, 1982. This HSP is then used in calculating a hospital's program reimbursement during the three year transition period for PPS. The HSP accounts for 75% of the payment rate in the first year of PPS, 50% in the second and 25% in the third. In the fourth year of PPS, the HSP will not be used in calculating payment rates, as they will be based entirely on a federal rate (unless Congress alters the transition schedule, which is presently under consideration).

2.2-1 Base Year Cost Appeals

The primary defect in the appeals process affecting PPS providers wishing to appeal base year costs relates to the timing for the filing of such appeals. According to the statutory language of 42 U.S.C. § 1395oo(a)(3), a provider may file a request for a hearing as soon as it receives "notice of the Secretary's final determination" regarding the provider's Medicare payments. Unlike the procedure established for providers receiving payment under cost reimbursement, there is no statutory reference to a "cost report" for PPS hospitals, although final settlement is contingent upon the filing of such reports. Hence by the literal terms of the statute, a hospital's right to appeal a PPS payment would arise when it is dissatisfied with the final determination of its intermediary as to the amount of the "payment" it is to receive, provided that the amount in controversy is $10,000[9/] or more. The first final determination for the provider would be the intermediary's issuance of its 1007 form, which establishes a hospital's HSP. Because of the rush to implement PPS, the process of issuing 1007 determinations was often chaotic, particularly,

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[9/] While the precise amount in controversy may not be known at the time a PPS provider wishes to file an appeal with the PRRB, satisfying jurisdictional requirements through a reasonable approximation of future injury is generally accepted in federal jurisprudence. See Hunt v. Washington State Apple Advertising Comm'n, 433 U.S. 333, 347 (1977); Bishop Clarkson Memorial Hospital v. Reserve Life Ins. Co., 350 F.2d 1006, 1008 (8th Cir. 1965).

but not exclusively, for hospitals with a September 30 year end. Under HCFA policy, hospitals were supposed to be given a three-week opportunity to comment upon proposed adjustments before the final 1007 determination was issued. Ironically, HCFA itself often directed adjustments for which no meaningful opportunity to comment was given to providers. HCFA would direct such adjustments when it conducted its so-called TRIM reviews, but the results of many TRIM reviews were not available until a few days before the commencement of the affected hospital's first year under PPS. In such instances, hospitals had no opportunity to object on factual or legal grounds to proposed adjustments. After entering PPS, any adjustments to base year costs would not be reflected in a hospital's HSP until the beginning of its next fiscal year. Thus, within any unusual definition, the 1007 determination is a "final" determination.[10]

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[10] Given that forms 1007 were only issued for the base year, in subsequent years separate "final" determinations are made by intermediaries each time they decide on the basis of a bill and other evidence submitted by a hospital that a certain amount is to be paid for a specific discharge covered by that bill. As was stated in the preamble to the PPS regulations published in the Federal Register on September 1, 1983, "[t]he prospective payments for inpatient hospital operating costs ... are intended to represent final payment for services rendered." 48 Fed. Reg. 39778, col. 3, (emphasis added). The payment being final, it would necessarily follow that the determination of that payment is "final." Thus, the payment iself should trigger a hospital's right to an appeal to the PRRB so long as $10,000 or more is in controversy.

Despite the fact that the statute itself does not have any requirements beyond that of a "final determination," on May 29, 1984 the HCFA Administrator issued Ruling 84-1 which states that the issuance of a Form 1007 is not a final determination for purposes of filing an appeal of base year costs. Instead, HCFA has interpreted the appeals statute as precluding providers from appealing their base year until an NPR has been issued for that cost reporting period. Since NPRs are generally not issued for at least a year after the close of a provider's cost reporting period, it could take up to three years following the close of a given cost reporting period for an appeal to reach final resolution at the Board. Since the base year costs only affect hospitals during the first three years of PPS, during which each hospital's HSP is used in calculating its reimbursement, it is very likely that a hospital's base year appeal would not be decided until after the PPS transition period has ended and hospitals are being reimbursed solely on the basis of a federal rate. Because of the "no retroactivity" rule discussed below, the effect of this policy is to render meaningless a successful base year appeal. To date HCFA's interpretation of the appeals statute has been challenged and its NPR requirement invalidated by the five federal district courts that have ruled on this issue. See Redbud Hospital District v. Heckler, No. C-84-4382-MHP (N.D. Cal. July 30, 1984); Charter Medical Corp. v. Heckler, No. C-84-116 A (N.D. Ga. March 20, 1985); Sunshine Health Systems, Inc. v. Heckler, No. CRV-85-953-AHS (C.D. Cal. April 10, 1985); Tucson Medical Center v. Heckler, No. 84-2437 (D.D.C. June 18, 1985); and Greenville Hospital System v. Heckler, No. 6: 85-337-3 (D.S.C. July 19, 1985). Legal precedent is therefore being established which hopefully will permit at least some providers to appeal base year determinations on the basis of their 1007 Forms.

While the recent court decisions relating to the appropriate timing for the filing of base year cost appeals will be of some assistance to providers pursuing such appeals, all providers must still deal with the PPS regulation which provides that any hospital ultimately succeeding in a base year costs appeal will be paid its base year costs but will not have its HSP adjusted until the beginning of its next cost reporting period. 42 C.F.R. § 412.(a)(3)(ii)(A). Often referred to as the "no retroactivity" rule, this rule means that hospitals cannot obtain retrospective relief based on having obtained an adjustment to their HSPs. Based on historical experience and the "final determination" issue discussed above, the vast majority of base year cost appeals will probably not be decided until after the three year transition period has ended at which point the HSP will no longer be relevant. This is particularly likely in view of the agency's increased penchant for litigating even after losing repeatedly in other cases involving the same issue.

Despite HCFA's steadfast adherence to its "no retroactivity" rule with respect to most base year cost adjustments, it has created some exceptions to the rule for other types of adjustments. While some of these exceptions are provided by statute (e.g., reclassification of a hospital as rural and census division determinations), others have simply been exempted by HCFA without any explanation as to why these adjustments may be given retroactive effect and base year cost adjustments may not. HCFA has also provided for retrospective adjustments whenever providers can demonstrate that the estimate of their base year adjustments to allowable costs was unreasonable and clearly erroneous. HCFA has also chosen to disregard the requirement that adjustments not be given effect until the start of the next cost reporting period in other selected situations. For example, if successful, a hospital appealing an adverse sole community hospital determination will be granted such status beginning 30 days from the date of the final decision. In creating these exceptions to the "no retroactivity" rule while strictly enforcing the rule as it applies to base year costs disputes, HCFA has been able to deny providers reimbursement to which they are rightfully entitled. While HCFA has suggested that retroactive adjustments to base year costs would create an administrative burden for the agency and the intermediaries, such adjustments would in fact be less burdensome than the reworking of cost reports that was required under the old cost reimbursement methods where there was retroactive relief. Hence, while an appeals process technically exists for the purpose of appealing base year cost disputes, HCFA's narrow interpretation of the appeals statute together with the PPS regulations regarding retroactivity have significantly diminished the meaningfulness of pursuing such appeals.

While the deficiencies in the appeals process for providers wishing to appeal base year cost adjustments could easily be overcome if HCFA would simply reverse itself on its interpretation of a "final determination", retract Ruling 84-1 and drop its "no retroactivity" rule, it is very unlikely that HCFA will take such action given the potential dollar amounts at stake. It is a more likely that, barring legislative intervention, these issues will continue to be resolved on a case-by-case basis in the courts.

2.2-2 Other PPS Appeal Issues

In addition to the cost-based reimbursement appeals which will continue to arise with respect to base year costs as well as other items of service which continue to be reimbursed on a cost basis, the reimbursement methodology under PPS has created new issues which will become the subject of the next generation of Medicare appeals. The first of these new areas of potential conflict is that of the federal rate which will ultimately be the sole basis for reimbursing providers for services rendered to Medicare beneficiaries. To date, the most controversial aspect of the federal rate has been geography.

Included within this rubric are such issues as the classification of a hospital as "urban" or "rural" and a hospital's location in a particular census division. Each of these classifications has reimbursement consequences. Closely related to these issues is the calculation of an accurate wage index for a particular geographic location in which a hospital is situated. Under existing regulations and policies, a provider disputing any of these issues relating to the federal rate may file an appeal with the PRRB pursuant to 42 U.S.C. § 1395oo within 180 days of receiving its NPR for the cost reporting period at issue. It is highly unlikely, however, that the issues will ultimately be decided by the PRRB, as such disputes will generally arise as a result of the regulations themselves, which the PRRB is bound to follow. In order to challenge these regulations, the hospitals will therefore have to pursue their judicial remedies. Once a final determination is made, it is not clear whether HCFA will give the final decision retroactive effect. As has already been pointed out, HCFA has been very inconsistent in its application of its "no retroactivity" rule.[11] The hospitals will therefore have to ask the courts to order retroactive relief as part of any judgment in a hospital's favor.

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[11] When it suits its purposes, HCFA has been known to enthusiastically embrace the concept of retroactivity. In the case of *District of Columbia Hospital Assoc., et al. v. Heckler*, No. 82-2520 (D.D.C. April 29, 1983), the U.S. District Court for the District of Columbia held that HCFA could not exclude wages paid by federal hospitals in establishing
(Footnote Continued)

Another area in which appeals will arise is that of the exceptions, exemption and adjustments provided for within the PPS regulations. Questions concerning whether the proper status of a hospital or hospital unit is correct will undoubtedly arise, as will issues regarding the availability of exception relief. Examples include the proper status of psychiatric units, rehabilitation units, cancer hospitals, sole community hospitals, referrals centers, children's hospitals and long-term care hospitals. In addition, disputes may arise with respect to the proper method for counting interns and residents, or beds, for purposes of calculating a hospital's indirect education adjuster. While providers may appeal any of these issues to the PRRB pursuant to 42 U.S.C. § 1395oo, it is unclear how providers are to calculate the amount in controversy in these types of disputes. Similarly, there is significant uncertainty as to whether or not the results of such appeals will be given retroactive effect. While HCFA has attempted to

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(Footnote Continued)
schedules for reimbursable wage costs without following APA rulemaking procedures. HCFA responded to this decision by issuing a Proposed Notice dealing with the exclusion of federal hospital wages on February 17, 1984 (49 Fed. Reg. 6175) and a Final Notice to that effect on November 26, 1984 (49 Fed. Reg. 46495). The Final Notice calls for the retroactive application of the federal wage exclusion.

apply the "no retroactivity" rule to appeals involving sole community hospital status, the courts have not been very receptive to this attempt on HCFA's part to deny hospitals their due.

While the traditional reimbursement appeals process is available to providers wishing to challenge some of the new determinations arising under PPS, the appeals procedures must be updated to accommodate these new issues. For example, new methods must be developed for calculating amounts in controversy in situations in which the traditional methods don't apply. The effect of a final decision in a given appeal must also be established. This very necessary updating of the appeal procedures may be accomplished through agency rulemaking or through legislation.

III. Part B Disputes

The Medicare Supplemental Insurance Program or Part B of the Medicare program provides coverage for "medical" services including physician visits, outpatient procedures, home health care, ambulance transportation, and durable medical equipment. While participation in Part B is optional, approximately 98% of all Medicare recipients elect to enroll in the Program.

The Part B appeals process established for providers and beneficiaries is very different from that established for

Part A inpatient services. The applicable appeals statute, 42 U.S.C. § 1395ff, specifically provides that a claimant is entitled to a hearing and judicial review of entitlement determinations under Part A and B and disputes regarding amounts of payment under Part A only.[12/]

The specific procedures to be followed in pursuing a Part B appeal are set out at 42 C.F.R. § 405.801 et seq. Pursuant to these regulations, a Part B denial may first be appealed through a "request for review" made to the entity which denied the claim. If the action taken on this request for review is still adverse to the party, and at least $100.00 is in controversy, an appeal can be taken to a Hearing Officer employed by the carrier or intermediary which issued the initial denial. While this appeal is known as a "Fair

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[12/] In the case of United States v. Erika, 456 U.S. 201 (1982), the Supreme Court interpreted the language of this statute as expressing Congress' intent to foreclose judicial review of adverse determinations regarding benefit amounts made under Part B of the Medicare program. The Court considered the legislative history of the statute and concluded that it was not unconstitutional, and that Congress was justified in developing a different appeals process for Part A and Part B, as Part B claims tended to be smaller and imposed a real threat of overloading the courts with minor disputes. In a case decided during the same term, Schweiker v. McClure, 456 U.S. 188 (1982), the Court again upheld the Part B appeals process stating that the hearing provided to beneficiaries, physicians, suppliers and providers is a sufficient due process hearing so as to satisfy constitutional due process requirements. Hence the constitutionality of the Part B appeals process has been established.

Hearing," there is little about the hearing which could be considered fair. Aside from the fact that the Hearing Officer is employed by the very organization that denied the claim at issue, the Hearing Officer is given full discretion to limit discovery in a particular case and is not permitted to overrule or modify a regulation, policy statement, instruction or other guide issued by HHS. Instructions, guides and policy statements are therefore treated as if they were law, despite the fact that they were never made the subject of the rulemaking procedures of the Administrative Procedure Act ("APA"). HHS may therefore violate the Medicare Act while rendering providers powerless to challenge such action. Finally, the most outrageous aspect of the Fair Hearing process is the fact that the Hearing Officer's decision is final and not subject to any further review. HHS is therefore given unbridled discretion to create its own body of law and apply it to Part B disputes regardless of whether this new law is consistent with the Medicare Act or promulgated in accordance with the APA.

In addition to providing a very limited review process for Part B claims, it should be noted that a Fair Hearing is not available to anyone with a claim of less than $100. Aside from the basic unfairness of denying individuals with small claims the same appeal rights as those with larger claims, a party may be denied a Fair Hearing because of this amount in controversy requirement while in the aggregate there may be thousands of dollars at issue. Unfortunately, the regulations do not generally permit aggregation of Part B claims for purposes of pursuing a Fair Hearing. The only time a party can aggregate claims is when all of the claims are for services rendered to a single patient.

The irony in describing the Part B appeals process as a Fair Hearing can best be illustrated through examples of actual cases that have been decided by Fair Hearing Officers.

CASE #1:

> This case involves an overpayment determination. In reviewing Part B claims paid for A, the carrier determined that a refund of $1,510.68 was due the Medicare program. It was determined that the overpayment was due to the fact that A's diagnosis and condition did not indicate that the use of ambulance transportation was medically necessary. This determination was made despite the fact that A was in a total body spica cast during the period of time during which he was using an ambulance. A was confined to bed during this time and only used an ambulance when travelling to the outpatient clinic for follow-up care. A had been treated for severe infection of the hip which required fusion and bone grafting.
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> According to A's physician, the ambulance services were necessary to allow A to remain supine or prone and to prevent jarring or movement which might cause failure of the bone graph thereby endangering the patients life and health. A was apparently transported by his family at one point, which according to the physician may have caused the failure of the first bone graph performed. Despite the clear evidence supporting the need for ambulance services, the Fair Hearing decision was to uphold the carrier's overpayment determination. The patient was thereafter ordered to refund the Program $1,510.68.

CASE #2:

In 1983 B underwent a total shoulder replacement. According to the bill submitted to her carrier, the surgeon charged $3,400 for the surgery and $680 for an services of the assistant surgeon. The "explanation of medical benefits" sent to B indicated that only $1,670 would be paid for the surgery and $391 for the assistant surgeon.

B asked for an initial reopening of the claim which was allegedly performed by her carrier resulting in a reaffirmation of the original decision. B then pursued a Fair Hearing which again resulted in a reaffirmation of the original determination. In the final decision rendered on July 6, 1984, the Hearing Officer concluded that the carrier had correctly processed the claim under the area's prevailing charge. The decision was based on technical language out of the Medicare claims manual and was totally incomprehensible to the beneficiary.

Among the bits of evidence available to the Hearing Officer at the Fair Hearing was a letter from B's physician stating that total shoulder replacement is the most difficult of the total joint replacement procedures and is technically more difficult to perform. Despite this evidence, upon reviewing the Fair Hearing decision, the carrier's medical policy staff asked four of its expert consultants to equate shoulder replacement with other joint replacements. These consultants concluded that a total shoulder replacement was equivalent to a total hip or total knee arthroplasty. On the basis of this determination the hearing decision was sustained. As a result of the lack of consideration given to B's physician's opinion, the carrier's determination became final and B was forced to borrow money in order to pay her physician's charges which were reduced in response to his outrage over the Fair Hearing decision.

When Congress created this limited appeals procedure in 1965 it presumably believed that Part B claims would involve only modest sums in contrast to Part A claims; the fact is however, very major issues can arise under Part B. For example, one hospital had more than $5,000,000 in outpatient claims questioned several years ago. It should also be noted that more and more services are being furnished in outpatient and non-institutional settings covered only under Part B and that PPS encourages this trend. New and increasingly sophisticated advances in medical technology are also making possible the performance of a wider range of outpatient surgical procedures.

It is therefore clear that the time has come for change. Such change will require legislative intervention as it will surely not come from within HHS. One HCFA official recently responded to some remedial recommendations made by the GAO regarding the processing of Part B claims by stating that the manual review of Part B claims and the possible increase in payments resulting from this review would be "counter to the current Program emphasis." By this time it should be apparent that the emphasis referred to by this HCFA official is one of denying beneficiaries and providers program payments however and whenever possible.

IV. Coverage Disputes

4.1 PRO Determinations

The PRO Program was created by the Peer Review Improvement Act of 1982. In accordance with Medicare regulation 42 C.F.R. § 466.78, every hospital, as a condition of payment, must have had an agreement with the PRO for its area effective no later than November 15, 1984. While these PRO agreements are similar to the review arrangements formerly entered into with the PSROs in that the reviewers are charged with analyzing claims for Part A services on the basis of reasonableness, medical necessity, quality and the appropriateness of the inpatient setting, there are several distinctions. The PROs, unlike the PSROs, cannot delegate review activities to the hospitals, are bound by objective criteria and have broader powers in recommending sanction and fines to be imposed on hospitals. Additionally, PROs are not entirely disinterested parties in the review process as their contract performance is judged by comparing actual denials to the target number established in their contracts. Overall, the PRO's primary objective is that of minimizing Medicare payments while maximizing the quality of services furnished to Medicare patients.

In reviewing a hospital admission for reasonableness, medical necessity, quality and the appropriateness of the inpatient setting, a PRO may conclude that the admission was not justified. Before considering the appeal rights of a provider and beneficiary following the denial of a hospital admission, it should be noted that a PRO's determination that an admission was unjustified would not necessarily result in a denial of payment for that admission. Pursuant to Section 1879 of the Social Security Act, reimbursement for Part A services rendered to a Medicare beneficiary may not be denied so long as the beneficiary and provider did not know and should not have had reason to know that the services were not covered by the program. Payment would be made for these services under what is known as the waiver of liability.

While there is a presumption that beneficiaries will generally be eligible for a waiver of liability, the PROs are responsible for conducting waiver of liability determinations for hospitals. If a PRO finds that three or 2.5% (whichever is greater) of all cases reviewed at a particular hospital are medically unnecessary, the hospital will no longer qualify for a waiver of liability. Consequently, if it is determined that a beneficiary did not know and could not have known that the services he or she received were not covered services and the provider does not qualify for waiver of liability, the provider will bear the loss of reimbursement and may not charge the beneficiary.

While the present appeals process does permit a provider to appeal an adverse PRO waiver of liability determination, the provider may not appeal the underlying coverage decision. Hence, even if a provider succeeds in appealing a waiver of liability determination, all future claims for the same service will be denied and the provider will no longer be eligible for waiver of liability. If the provider continues to provide the service at issue it will therefore be denied reimbursement, will be prohibited from billing the beneficiary and will be denied the opportunity to challenge the adverse coverage determination.

While it has been suggested that providers should not be concerned with coverage decisions as they are between the program and its beneficiaries, as noted above, the waiver of liability has created a financial risk for providers. Additionally, in the event that a provider and beneficiary both lose their waiver of liability, which would permit the provider to bill the beneficiary for the services rendered, the provider would, as the Fifth Circuit determined in Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger, 517 F.2d 329 (1975), have a legitimate interest in the coverage decision as that decision would determine whether the government is its debtor or the beneficiary, who may be hard to find and harder to collect from. Despite these very legitimate interests of providers in coverage determinations, the present PRO appeals process permits only beneficiaries to appeal these decisions (the only appeal right available to a provider would be that of challenging the waiver of liability determination). In view of the fact that beneficiaries are protected by the favorable waiver of liability presumption however, it is unlikely that a beneficiary would bother pursuing an appeal unless the particular service involved was one that he/she anticipated needing again in the future. (While beneficiaries might be more willing to pursue appeals if they could be represented by their providers, as will be discussed in Section 4.2, HCFA has specifically prohibited providers from representing beneficiaries in Medicare appeals.)[13/]

In reviewing the appeals process established for the review of PRO determinations, it is obvious that the greatest appeal rights are vested in those with the least incentive to pursue them. While a provider can request a reconsideration of a PRO's initial denial determination, which would involve a de novo review by at least one physician who was not associated with either the PRO's original decision or the patient, there are no provisions for an appeal beyond this reconsideration. Additionally, while the reconsideration is supposed to be done by a specialist in the practice area involved, the PRO can avoid this requirement if such a specialist is not available. In contrast to this limited appeal right afforded to providers, beneficiaries may appeal coverage decisions of at least $200 to an ALJ. If the amount in controversy is at least $2,000 the beneficiary can appeal an adverse ALJ decision in federal district court.

13/ In addition, HCFA has made known its intention to abolish the favorable presumption at least insofar as hospitals are concerned. Such a decision, should it come to pass, will only exacerbate the situation.

Given that the appeals process for challenging PRO determinations was developed by HCFA, the decision to grant providers very limited appeal rights, which is chief among the shortcoming of this process, obviously has substantial support within the agency. Hence, in order to remedy the deficiencies in the PRO appeals process, providers will probably need to seek legislative intervention.

In addition to the individual coverage decisions from which providers have limited recourse, the PROs are also empowered to make sanction recommendations to HHS if they detect patterns of inappropriate or unnecessary medical care. All providers are given an opportunity to respond to sanction recommendations; however, if a provider is excluded from the program as a result of a PRO recommendation, the provider's first real opportunity to appeal this determination to an independent party would not be until after its exclusion from the program. While the provider could appeal this final decision to an ALJ and ultimately in federal district court, the exclusion sanction would not be postponed pending the outcome of this appeal. While the fact that providers are not given a pre-exclusion hearing seems patently unfair given the consequences of exclusion from the program, this unfairness is exacerbated by the fact that PROs are not required to have their sanction recommendations reviewed internally by PRO personnel who were not involved in investigating the alleged violation which resulted in the sanction recommendation. These deficiencies in the sanctioning process, alike those identified with respect to PRO coverage appeals, will undoubtedly require legislative corrective action, as HCFA is not apt to expand providers' right beyond those already set out in the PRO regulations.

4.2 DRG Validations

In addition to their other review functions, PROs must conduct DRG validation reviews. The purposes of a validation review are to ascertain: 1) whether the hospital's choice for a DRG is supported by the medical record; and 2) that the physician's attestation appears.

A DRG validation review is a part of each of the other types of PRO review. In addition, however, the PRO must perform a validation review on, at least, an additional 3% random sample of claims. (In the future, HCFA proposes to have DRG validation reviews focus on known and potential problem DRGs and to eliminate or reduce the random sample review.) Claims submitted for DRGs 462 (Rehabilitation) and 468 (Unrelated OR Procedure) automatically are subjected to a validation review, as will all other PPS cases which are retrospectively reviewed for other reasons. Separate validation reviews must be conducted quarterly.

Adequate documentation regarding the principal diagnosis, procedures, secondary diagnoses, complications, and comorbidities must all be in the medical record. If the PRO's DRG validation review results in recategorizing 2.5% of the reviewed claims or 3 claims, whichever is greater, the PRO will place the hospital on intensified review. The intensified review will be of 100% of any categories identified as giving rise to more errors. If no specific categories can be identified, the PRO will expand its DRG validation review in the future to at least 20% of the hospital's Medicare charts. Sometimes, the PRO will find that there is a "significant pattern" (i.e., the greater of 2.5% or 3 cases) of coding error for a particular physician. If so, the PRO will target 100% of that physician's charts for intensified review.

Certain DRGs have been identified as troublesome. After initial reviews, the Office of the Inspector General reports that it has found high error rates for three DRGs. The three DRGs that OIG has found to be most troublesome are: DRG 88, chronic obstructive pulmonary disease; DRG 14, cerebral vascular disorders; and DRG 22, respiratory neoplasms. Of the total claims examined under DRG 88, chronic obstructive pulmonary disease, OIG reported that: 59% were "upcoded" from the proper DRG; 22% were coded in favor of the government; and only 19% were properly assignable to DRG 88. This finding is particularly significant because chronic obstructive pulmonary disease is one of the most commonly assigned Medicare DRGs on a nationwide basis. While less dramatic, OIG reported 30% error rates for both DRG 14, cerebral vascular disorders, and DRG 22, respiratory neoplasms, with the vast majority of the errors being in the hospital's favor.

Given that a hospital's reimbursement for a particular case will depend on its DRG classification, the hospital would obviously have a strong interest in appealing a PRO's reclassification of that case into a DRG with an lower payment rate. A physician might also have an interest in appealing such a reclassification, as it represents a direct challenge to his/her medical judgment. Despite these legitimate interests of hospitals and physicians, the only appeal right available to either group is that of a reconsideration. Beyond this reconsideration, hospitals and physicians have absolutely no recourse and must abide by the subjective yet final determinations of the PROs with respect to DRG reclassifications. Beneficiaries have even fewer appeal rights in this area, as they are not even eligible for reconsiderations. Hence, despite the power vested in the PROs to second guess medical judgments and decrease program payments, those most directly affected by these decisions, the hospitals, have very limited rights in appealing these actions.

Given the wording of the PRO reconsideration and appeals statute, it clearly will require legislation to enable providers and physicians to appeal adverse PRO determinations.

4.3 Technical Coverage Denials

HHS has begun imposing so-called "technical" denials on home health agencies. A technical denial is defined as the denial of a visit based on an intermediary's determination that the visit failed to meet a statutory or regulatory requirement other than medical necessity. Unlike other Part A coverage determinations, technical denials are not subject to waiver of liability. A provider would therefore be denied reimbursement without any consideration of whether it knew or should have known that the service was not covered. Providers are therefore offered no appeal rights under any circumstances. Given that the limitations on the appeal rights of providers with respect to technical denials were established by HHS, legislation would undoubtedly be required to remedy this deficiency in the appeals process.

Two common examples of a technical denial involve situations in which the intermediary determines a patient did not meet the "homebound" or "in need of intermittent skilled nursing care" requirement for home health services. Given that the terms "homebound," "intermittent" and "skilled nursing care" are subject to multiple interpretations, one would expect technical denial decisions to be appealable. Unfortunately, such denials are only appealable by beneficiaries who often lack the resources or the physical ability to pursue such appeals.

Again, legislation will be necessary to correct his problem.

V. Challenges to Final Rules, Regulations and Policies Issued by HHS

5.1 Challenging Final Rules

Over the past ten years the Supreme Court and various lower courts have narrowed the avenues a plaintiff may take to establish jurisdiction when challenging Medicare regulations. In the case of Weinberger v. Salfi, 422 U.S. 749 (1975), the Supreme Court held that Social Security claimants who seek to challenge the disposition of a claim for benefits must follow the administrative appeals procedure before being entitled to judicial review. For purposes of challenging Medicare provider reimbursement regulations, that administrative appeals procedure is set out at 42 U.S.C. § 1395oo. According to that statute, only final decisions of the Provider Reimbursement Review Board or affirmances, reversals, or modifications of PRRB decisions by the Secretary are subject to judicial review. This requirement makes it virtually impossible to challenge a final rule issued by HCFA until many years later.

Last term, the Supreme Court again addressed the question of whether a federal court has jurisdiction to consider a claimant's challenge to Medicare rules and policies without first submitting a claim and exhausting administrative remedies. Heckler v. Ringer, 104 S.Ct. 2013 (1984). In Ringer, the Court held that whenever a party is in a position to submit a claim to the Secretary for adjudication they must do so and follow the procedure prescribed by the statute; otherwise, district courts do not have jurisdiction to consider a potential claim as a challenge to the Secretary's procedures. According to the Court, a claimant must submit a claim, have it adjudicated and exhaust his/her administrative remedies before a court can consider the merits of the claim or challenges to the relevant procedures. The Ringer court viewed procedural challenges as being inextricably bound to claims for reimbursement, making it almost impossible to demonstrate otherwise.

In light of the Supreme Court's holding in Ringer, it is difficult for providers wishing to challenge final rules issued by HHS at the time of promulgation. Given the requirement that all administrative remedies be exhausted, providers have to wait until an NPR has been issued for the first cost reporting period during which they were subject to the rule at issue. The jurisdictional requirements for challenging Medicare rules and regulations therefore render such challenges incredibly time consuming and potentially futile in instances where the effects of a particular rule are short-lived and retroactive relief is unavailable.

The dispute over the so-called "malpractice rule" is but one example of the tremendous waste of money, time and energy which can result from the enforcement of the jurisdictional requirements imposed on providers wishing to challenge Medicare rules and regulations. On June 1, 1979, HCFA issued its new malpractice rule which required providers to alter the formula used in calculating their allowable malpractice insurance costs. While the providers recognized the deficiencies in this new rule as well as the rulemaking record developed to support it, when they attempted to challenge the rule in court, the U.S. District Court for Kansas refused to waive the procedural requirements of 42 U.S.C. § 1395oo and assume jurisdiction over the challenge. Hadley Memorial Hospital v. Harris, No. 79-4172 (D.Ka. June 3, 1980), aff'd, 689 F.2d 905 (10th Cir. 1982). Instead, providers were forced to await the issuance of their first NPR under the new malpractice rule and pursue appeals to the PRRB and onto the federal district courts. While the rule has been invalidated by seven courts of appeals and twenty-six district courts, HHS has not given up its fight and is now proposing a repromulgation of the rule with an allegedly stronger rulemaking record, and will make the newly promulgated rule retroactively effective back to July 1, 1979. HHS is therefore attempting to reverse all favorable court decisions relating to the malpractice rule. While providers will now have to pursue their appeal rights once again in challenging the new rule, a great deal of money, time and energy could have been saved and the issue probably resolved by now, one way or the other, had providers been permitted to challenge the rule when it was first issued in 1979.

Given that HHS has gone to court on numerous occasions to preserve its right to prevent providers from challenging agency rules and regulations in a timely fashion, it is unlikely that it will back down now, despite the evidence that its jurisdictional obstacles only serve to waste the agency's time and money. Instead, providers should focus their attention on Congress and seek legislation which would permit them to pursue timely challenges to agency rules and regulations.

5.2 Challenging HCFA's Disregard for the APA - Promulgation of Policy Prohibiting Providers From Representing Beneficiaries in Medicare Appeals

The Administrative Procedure Act sets out the rulemaking procedures to be followed by administrative agencies in the promulgation of agency rules and regulations. This rulemaking procedure includes a detailed notice and comment requirement. While most administrative agencies are bound by the APA, case law has recognized the "benefits" exception to the APA, which would exempt Medicare rulemaking. Humana of South Carolina

Inc. v. Califano, 590 F.2d 1070 (D.D.C. 1978). In 1971, the Department of Health, Education and Welfare waived the APA "benefits" exception in response to strong indications that the exemptions would otherwise be removed statutorily. Since that time, Medicare has been subject to the APA by virtue of its own waiver of this exemption.[14] Consequently, there has always been ongoing concern as to whether HHS is consistently abiding by the APA in the promulgation of its various rules and regulations. While certainty in this regard would require a legislative directive requiring HHS to abide by the APA, the agency policy against providers representing beneficiaries in Medicare appeals is one example of a situation in which HCFA appears to have ignored a specific statutory mandate as well as the rulemaking requirements of the APA.

While Section 1869 of the Social Security Act entitles Medicare beneficiaries to administrative and judicial review of adverse Part A payment determinations, 20 C.F.R. § 404.1705(b) provides that beneficiaries may be represented by any individual not prohibited by law from acting as such. By statute, the Secretary of HHS is given the authority to prescribe rules and regulations governing the recognition of agents or other persons representing claimants before the Secretary in Medicare disputes. Hence, so long as a potential representative meets the criteria set out at 20 C.F.R. § 404.1705(b), they may not be prohibited from representing beneficiaries unless the Secretary has done so through the promulgation of a rule or regulation. Such a rule or regulation would have to be promulgated in accordance with the APA.

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[14] On June 22, 1982, HHS proposed in the Federal Register to adopt a regulation concerning its APA obligations which rather than affirming its waiver of the "benefits" exception would have permitted it to dispense with APA requirements whenever "such procedures would impair the attainment of program objectives." 47 Fed. Reg. 26860, col. 3. A Final Rule to that effect has never been published.

Despite the clear statutory language of 42 U.S.C. § 406(a), HCFA issued Intermediary Manual Section 3789(c) in January of 1984 thereby prohibiting providers from representing beneficiaries in Medicare appeals. In so doing, HHS not only ignored the APA, but violated a specific statutory provision requiring rulemaking. Nevertheless HCFA has continued to enforce Intermediary Manual Section 3789(c).

In addition to having violated the APA and the clear statutory language of 42 U.S.C. § 406(a), HHS has denied much needed assistance to beneficiaries by precluding providers from serving as their representatives in Medicare appeals. While HHS has argued that the prohibition against provider representation is necessary in order to avoid conflicts of interest, there are very few instances, if any, in which such conflicts would arise as agreed to by beneficiary groups that have testified and will testify. Given that both beneficiaries and providers have the same basic interest, that of favorable coverage determinations, it is patently absurd to prohibit provider representation in order to remedy a problem which will only rarely arise. In those isolated situations in which conflicts might exist, a more logical remedy would be to mandate an agreement between the provider and beneficiary which would hold the beneficiary harmless if he/she were deemed liable for an overpayment. If such agreements were required, there would be no justification for instituting a policy as overbroad as the total prohibition against provider representation of beneficiaries in Medicare appeals.

When the prohibition against provider representation is considered along with various other aspects of the Medicare appeals processes already described, one is drawn to the inevitable conclusion that HHS is once again attempting to reduce the number of successful Medicare appeals. By prohibiting provider representation, beneficiaries with few incentives to pursue appeals will choose not to and those with an incentive will be denied the knowledge and resources which providers could otherwise bring to bear in such appeals.

In light of HCFA's position with respect to the representation of beneficiaries by providers, it is highly unlikely that it would consider retracting Intermediary Section 3789(c). This defect in the Part A appeals process would therefore best be remedied through legislative action.

Summary

As should be apparent from the foregoing analysis of the various appeals processes established for Medicare providers, the appeals system is replete with procedural road-blocks to due process. While each individual inequity within the Medicare appeals system has been justified by HHS as a means of avoiding conflicts of interest or controlling the amount of Medicare litigation; taken together, the various aspects of this system send clear messages to providers and beneficiaries that pursuing appeal rights can be a very expensive and frequently futile endeavor.

AJL/cep/AJL012/02

STATEMENT OF LINDA BILLOWS, ADMINISTRATOR, VISITING NURSES ASSOCIATION OF GREATER SALEM, INC., SALEM, MA; ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. BILLOWS. Mr. Chairman, my name is Linda Billows. I am the executive director of the Visiting Nurse Association of Greater Salem, Salem, MA. I am here in my capacity as a member of the Government Affairs Committee and the board of directors of the National Association for Home Care. The National Association for Home Care is the Nation's largest organization representing home care and hospice providers.

I am very pleased to have the opportunity to present NAHC's views of the Medicare appeals process. I would like to commend the committee for holding this important hearing. I would also like to commend you, Mr. Chairman, for the introduction of Senate bill 1551. NAHC strongly supports this legislation.

As you know, NAHC has participated actively in the efforts of the Medicare Appeals Coalition—a coalition of providers and beneficiaries who have worked very hard in coming together and identifying the problems in the current appeals process.

My testimony today will focus on why this legislation is needed and will explore several other problems relating to the Medicare appeals process.

In January of 1984, the Health Care Financing Administration issued a revision to the Home Health Agency Manual known as HIM-11. This manual contains guidelines and interpretations of regulations and operating policies which HCFA requires home health agencies certified for Medicare to follow.

The January 1984 revision prohibited Medicare from designating home health agency employees to represent them in any aspect of the Medicare claims appeal process. The rationale stated by HCFA was that such representation by a home health agency always represents a conflict of interest. Absolutely no factual support was provided by HCFA for its assertions about conflict of interest.

Prior to January 1984, the selection of a home health agency as a beneficiary's representative had been an acceptable occurrence for many years. Medicare patients, their families and home health agencies were shocked by the issuance of the revisions. Medicare beneficiaries are frequently unable, from a practical and medical viewpoint, to handle the taxing requirements of a claim's denial and appeal process. The home health agency has traditionally served as a medical and emotional support for these people and as the appropriate representative. NAHC believes that HCFA's actions in promulgating the revisions constitutes an unwarranted destruction of the exercise of the appeal-rights process.

In March 1984, NAHC filed a lawsuit on behalf of several Medicare beneficiaries and providers. The current status of this lawsuit is that the Federal court judge ruled in favor of hearing a lawsuit and ordered the Department of Health and Human Services to stop resisting providing information and instead start cooperating. Although we have every expectation of winning on the merits of the lawsuit, the year and a half of delaying tactics has left both beneficiaries and providers in a limbo status. S. 1551 would provide appropriate legislative redress, by clarifying in no uncertain terms the right of Medicare beneficiaries.

Technical denials is another issue where we have had some difficulties. A technical denial is the denial of a visit based on an FI's determination that the visit failed to meet a statutory or regulatory requirement other than medical necessity. Examples of such denials would be where an F1 found a patient did not meet "homebound" or "in need of intermittent skilled nursing care" eligibility requirements.

Our written statement elaborates on some of these difficulties and suggests language which may remedy the situation.

There are also several other issues in the appeals process that have presented great difficulty, and, once again, our written statement elaborates on these.

In summary, NAHC supports the enactment of S. 1551 and urges this committee to consider legislative redress for both the technical denials issue as well as HCFA's interference with the appeals-rights process.

We would be pleased to provide any assistance to the committee and any other additional information. Thank you.

Senator Durenberger. Thank you very much.

Jack.

[Ms. Billow's written testimony follows:]

STATEMENT OF LINDA BILLOWS, ADMINISTRATOR

VNA OF GREATER SALEM, INC.
SALEM, MASSACHUSETTS

on behalf of the

NATIONAL ASSOCIATION FOR HOME CARE

before the

COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
UNITED STATES SENATE

The Honorable Dave Durenburger, Chairman

Washington, D.C.

November 1, 1985

Mr. Chairman and Members of the Committee:

My name is Linda Billows. I am the Administrator of the VNA of Greater Salem, Inc. in Salem, Massachusetts. I am here in my capacity as a member of the Government Affairs Committee and the Board of Directors of the National Association for Home Care (NAHC).

The National Association for Home Care is the nation's largest organization representing home care and hospice providers and individual home care professionals and paraprofessionals. NAHC's nearly 3,000 members include large and small home health agencies, freestanding, hospital, and nursing home-based agencies, Visiting Nurse Associations, major corporate chains, homemaker-home health aide agencies, and hospices.

I am very pleased to have the opportunity to present NAHC's views on the Medicare appeals process and would like to commend this Committee for holding this important hearing in recognition of the need to re-examine the current system.

I would also like to commend you, Mr. Chairman, and Senators Heinz and Chafee for your introduction of S. 1551. NAHC strongly supports this legislation. NAHC has participated actively in the efforts of the Medicare Appeals Coalition, a coalition of provider and beneficiary groups who worked together to identify the problems in the current Medicare appeals system and sought the introduction of legislation to remedy current inadequacies. S. 1551 is a necessary step towards achieving that goal. My testimony today will focus on why this legislation is needed and will explore several other problems relating to the Medicare appeals system which we feel also warrant legislative relief.

THE NEED FOR S. 1551

In January 1984, the Health Care Financing Administration (HCFA) issued a revision to the Home Health Agency Manual known as "HIM-11". This manual contains guidelines and interpretations of regulations and operating policy which HCFA requires home health agencies certified for Medicare to follow. The January 1984 revision of Section 257 of HIM-11 prohibits Medicare beneficiaries from designating home health agency (HHA) employees to represent them in any aspect of the Medicare claims denial appeal process. Similar revisions to manuals were issued dealing with SNF and hospital employees. The rationale stated by HCFA was that such representation by an HHA on behalf of a Medicare beneficiary always represents a "conflict of interest". Absolutely no factual support was provided by HCFA for its assertions about "conflict of interest".

Until January 1984, the selection of a HHA as a beneficiary's representative had been an accepted and an acceptable occurrence for many years. Medicare patients, their families and HHAs were shocked by the issuance of this manual revision. Medicare beneficiaries are frequently unable from a practical and medical viewpoint to handle the taxing requirements which are part of the claims denial and appeals process. The HHA has traditionally served as a medical and emotional support for these people and thus is a natural as well as an appropriate representative. A Medicare beneficiary and an HHA have mutual, compatible interests in having erroneous coverage denials overturned.

NAHC believes that HCFA's actions in promulgating the manual revision constitute an unwarranted destruction of the exercise of appeal rights of Medicare beneficiaries and providers. On March 26, 1984, NAHC filed a lawsuit on behalf of several Medicare beneficiaries and providers to contest HCFA's issuance (NAHC, et. al. v. Heckler, Civil Action No. 84-0957, U.S.D.C., District of Columbia). The current status of this lawsuit is that the federal court judge ruled in favor of hearing the lawsuit and ordered the Department of Health and Human Services to stop resisting providing information and instead, start cooperating. Although we have every expectation of winning on the merits based upon the Medicare statute and regulations as currently written, the Department's delaying tactics over a year and half of litigation place beneficiaries and home health providers in a limbo state. S. 1551 would provide appropriate legislative redress by clarifying in no uncertain terms the right of Medicare beneficiaries to designate providers as their representatives in the claims appeal process.

S. 1551 would also provide much-needed reform of the Part B appeals process. NAHC supports this expansion of Part B appeals rights.

CURRENT MEDICARE APPEALS ISSUES AFFECTING BENEFICIARIES AND HOME HEALTH PROVIDERS

Technical Denials

Without resort to fair rulemaking procedures required under law, HCFA policymakers have created a form of Medicare claims denial which does not exist in the Medicare law or regulations: so-called "technical denials" are being imposed on home health agencies (HHAs). A "technical denial" is a denial of a visit based on the fiscal intermediary's (FI's) determination that the visit failed to meet a statutory or regulatory requirement, other than medical necessity. Technical denials are not subject to waiver of liability and are appealable only by the beneficiary. Examples of technical denials would be ones where the FI finds the client did not meet the homebound or "in need of intermittent skilled nursing care" eligibility requirements or received a non-skilled or other service allegedly not covered under the Medicare home health benefit.

Since terms like "homebound," "intermittent," and "skilled nursing" are subject to multiple interpretations, the HHA should have the right to appeal such denials directly. Such "technical" terms are no more definitive than the term "medical necessity" — a term not subject to the technical denial policy. "Homebound", "intermittent", and "skilled nursing" are terms directly relating to medical orders which physicians sign to permit HHAs to render care under the home health benefit, and to the medical and nursing assessments of the patients which the HHA must perform on an ongoing basis. Medicare beneficiaries rely upon these medical and nursing assessments as part of the natural reliance of patient and professional in our health care system. The HHA relies upon the patient for accurate information abut the patient's activities and subjective responses to treatment. HCFA's "technical denial" policy fractures this relationship of caregiver and patient and is an illogical interpretation of the statute as now written.

Most Medicare patients and their families or survivors may lack either the understanding or the stamina to appeal a "technical denial" on their own. As I noted before, HCFA has attempted to bar the beneficiary from using the HHA as a representative. Because of the strained financial and emotional situations of the typical Medicare home health patient, it is simply not realistic for home health agencies to expect or even attempt to recoup from such frail people the costs of months of care disallowed by FI's, abruptly and retroactively. The HHA, of course, will have already paid its staff for services, and thus will be left with tremendous financial strain.

To summarize, the HHA is harmed by technical denials because it must absorb the cost of the services rendered and has no recourse to waiver or the appellate process for redress. The Medicare beneficiary is harmed because his or her natural ally -- the HHA which rendered care -- is barred from joining in or leading the appeal. Quite frankly, we fear also that Medicare beneficiaries will be adversely affected in the future. Home health agencies facing severe monetary losses from "technical" denials will begin to limit admissions of patients whose care might result in a technical denial. As you well know, the interpretation of what is "intermittent" care has been used by HCFA in a fashion that the home health industry and beneficiary groups believes is illegal. In an overwhelming percent of cases where "intermittent" denials reach the impartial administrative law judge level, there is a victory for the patient and for the HHA's judgment in giving services. If HHAs cannot be confident that these appeals will be brought, and successfully won, HHAs will begin to limit the number of these patients and HCFA will have succeeded in narrowing the home health benefit.

NAHC believes that the technical denial issue is an appropriate one for legislative redress. We recommend that subsection 1869 (b)(1) of the Social Security Act, 42 U.S.C. section 1395 ff(b)(1) be amended to read:

> (1) Any individual dissatisfied with any determination under subsection (a) as to —
>
> (C) The amount of benefits under part A (including a determination where such amount is determined to be zero)
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing is provided in section 205(g). In any case arising under subparagraph (C) (but without regard to whether payments have been made by the individual to the provider), the provider shall have the same rights as an individual under paragraph (1), except that such rights may, under prescribed regulations, be exercised by such provider only after the Secretary determines that the individual will not exercise such rights under the paragraph.

This proposed legislative change would permit a home health agency to appeal a denial of coverage based upon a fiscal intermediary's judgment that a patient was not "homebound" or was receiving the inappropriate level of care (not "intermittent"), although the HHA, the patient, patient's family and attending physician all consider him to have been homebound within medical and statutory terms or properly receiving care in a home setting as to frequency and intensity. HCFA has been using the "technical" label to suggest that care is not that for which patient is eligible under Medicare, knowing that in many cases the elderly or infirm patient will not have resources to bring appeal, may not have survived to appeal or may not be able to pay the home health agency for care when the technical denial is made.

ABRIDGEMENT OF APPEAL RIGHTS

In a recent series of actions, the Department of Health and Human Services and its agents have acted to obliterate, discourage or skew the existing appeal process available under Medicare statutory provisions and regulations.

1. Projection of Part A Claims Denials onto Universe of Claims

In one of the most outrageous examples of abuse of appeal procedures, the Department has reviewed individual beneficiary Part A cases in several home health agencies and, finding some alleged coverage questions in a small percentage of sampled cases, has projected those denials over all the visits and claims of a home health agency throughout its cost year. HCFA's demand for repayment of this astonishingly inflated dollar figure for unknown beneficiaries' care and unknown hypothetical coverage errors means that those Medicare beneficiaries and the provider cannot utilize any Part A appeal process for review of the facts in those cases. Appeal rights which Congress, has established 42 (U.S.C. Section 1395 pp.) are simply obliterated. Despite numerous attempts to negotiate and contacts from concerned Members of Congress, the Department is persisting in applying this illegal tactic. I will note for the record that none of these cases involve any finding of fraud or violation of the statutory provisions administered by the Inspector General's Office.

NAHC is financing the appeal of this legal issue on behalf of home health agencies in New Mexico. One administrative law judge has already held that the Department's statistical projection tactic is illegal. I will submit for the record a copy of this opinion. Incredibly, the Department continues to assess hundreds of thousands of dollars in illegally inflated claims for recoupment against other home health agencies and providers.

2. Interference with Appeal Process

The Department has also attempted to interject itself as a party in various appeal procedures where, by the Department's own regulations, there is no appropriate Departmental role. For example, the Department has tried to appear at the administrative law judge (ALJ) proceedings for review of claims denials. The Department, through its Regional Offices, also has attempted to alter appeals procedures before the Appeals Council which, by regulation, is an independent entity that reviews ALJ decisions on its own motion or by request of providers or beneficiaries only. Numerous letters have gone from the HCFA Region IV Office in Atlanta to the Appeals Council asking it to reverse ALJ opinions favoring providers and beneficiaries. Nothing in the law or regulations permits such interference in the appeal process.

3. Chilling The Exercise of Appeal Rights

The same Departmental Regional Office in Atlanta was responsible for a questionnaire sent earlier this year to Medicare beneficiaries who had requested reconsideration of denials of their Medicare claims -- the very first level of appeal. The HCFA questionnaire asked for verification of signature, asked for the contents of any communication about the appeal between the beneficiary and the home health agency which had served him/her; and then ended with the inquiry "do you still wish to have reconsideration of this claim?" Such a communication to an elderly, infirm population of beneficiaries who frequently can be easily alarmed or dissuaded from asserting their rights in an aggressive fashion is an outrage. Furthermore, there is an obvious breach of privacy attempted in the questioning. NAHC has shared information on this issue with beneficiary groups such as the National Senior Citizens Law Center. They are outraged as well.

Imagine the compounded impact on these frail people when we tell you that certain administrative law judges were phoning or having their secretaries phone beneficiaries and their families in Region IV telling them that pursuing their rights through a hearing was not in their best interests. No swift action ensued from any Departmental office to rectify this abridgment of Medicare patients' rights. Instead, the Department is attempting to frighten aged, infirm people who may or may not remember executing their own signature, or whose family members, wishing to assist in appealing unfair denials, have assisted patients in filing appeals.

SUMMARY AND CONCLUSION

In summary, NAHC supports the enactment of S. 1551 and urges this Committee to consider legislative redress for both the "technical denials" issue and for HCFA's interference with appeals rights.

NAHC would be pleased to provide assistance to this Committee in its consideration of reforms in the Medicare appeals process. I appreciate the opportunity to present NAHC's views today and would be happy to respond to any questions you might have.

OFFICE OF HEARINGS AND APPEALS

SOCIAL SECURITY ADMINISTRATION

In the Matter Of)
)
ALBUQUERQUE VISITING NURSING) DOCKET NO. HIP-000-61-0022
SERVICES, INC.)
)

SUPPLEMENTAL PRE-HEARING ORDER

Pursuant to notice, a pre-hearing conference was held in this matter, before the undersigned, on February 19, 1985. Certain jurisdictional and procedural issues were raised, and as a result, the undersigned issued a pre-hearing order directing counsel to prepare and present pre-hearing memoranda concerning certain of those issues. The memoranda of counsel having been received, and the undersigned being now fully advised, further pre-hearing order is hereby issued as follows:

1.The Administrative Law Judge does have jurisdiction to hear and decide the issue of the authority of HCFA to use, or direct the use of, a sampling method in assessing an overpayment against a provider under Medicare Part A.

2.HCFA does not have the authority to use, or direct the use of, a sample in projecting the assessment of overpayment against AVNS to the universe of Medicare Part A claims submitted from March 5, 1982 through March 25, 1983.

3.HCFA does not have a right to appear as a party and be represented by counsel at a hearing to determine the merits of individual cases on appeal.

RATIONALE

The jurisdiction and authority of an Administrative Law Judge derives from statutory enactments. In this instance, the basic authorization is found at 42 U.S.C. 1395ff, providing for a hearing on determination of the amount of benefits to which an individual is entitled under Medicare Part A, "by the Secretary to the same extent as is provided in Section 205b..." 42 U.S.C. 405. Section 205b of the Social Security Act (Act) authorizes the Secretary to make rules and regulations and to establish procedures which are necessary to carry out the provisions of the Social Security Act, and directs the Secretary to make findings of fact and decisions as to the rights of any individual applying for benefits under the Act. Pursuant to this authority, the Secretary has promulgated regulations providing for the hearing process before a duly appointed Administrative Law Judge. Specifically, 42 CFR 405.701 incorporates the provisions of Subpart J of 20 CFR Part 404 in detailing the hearing process to be applied. In rendering a decision on entitlement to hospital insurance benefits and the amount payable, the Administrative Law Judge must apply the applicable law, i.e., the statutes and valid regulations, to the facts presented. Thus, it is clear that an Administrative Law Judge has the authority and duty to hear and decide appeals from adverse determinations on eligibility and amount of payment under Medicare Part A. This perforce includes the authority to examine the method used in arriving at a denial of a claim or claims.

The government concedes that there is no direct statutory authority for use of sampling to project an overpayment to a universe of Medicare Part A claims, but contends that the authority is implied, either for administrative necessity, due to the "enormous logistical problems in enforcement", or by analogy to the sampling method authorized for assessing civil money penalties, 45 CFR 101.101. In any event, use of sampling in Medicare Part A cases is said to be a valid, accepted agency policy.

These contentions are not well taken. Difficulty in enforcement cannot in any case confer authority for the government to act in contravention of law, or confer authority to take action against individuals or private organizations where no such authority has been granted by Congress. The procedures for processing Medicare Part A claims, the remedies for recovery of overpayment on improper claims, the rights of the parties against each other, and the rights to appeal are all clearly delineated in the statutes and the regulations fully promulgated thereunder. Use of a sampling method contravenes those procedures and abrogates those rights. See 42 U.S.C. 1395ff and 1395pp and 42 CFR 701 et seq. Individual review of each case is mandated. The liability of the provider, the individual and HCFA may only be determined by a fact review of each case.

Nor is an analogy to the Civil Money Penalty provision of 45 CFR 101.100 et seq. well taken. The basis for civil money penalty is, by its nature, different from assessment of overpayment in Medicare Part A cases. Civil money penalties are punative in nature, and assessed only against the provider for his improper or illegal actions. They may not be passed on to the individual beneficiary nor may the beneficiary be charged with the cost of services as may be the case in Medicare Part A claims. Authority for projection of a sample in civil money penalty cases cannot be transferred to Medicare Part A cases, where the effect would be an unauthorized reduction in the statutorily granted rights of the provider and beneficiary.

Case law on which HCFA relies does not provide direct support for its position. Both the Mt. Sinai and Daytona Beach cases (Mt. Sinai Medical Center v Weinberger, 522 F 2nd 179 (5th Cir. 1975), Daytona Beach General Hospital v Weinberger, 435 Fed. Supp. 891 (M.D. Fla. 1977)) arose before the 1972 amendments establishing notice and appeal rights of a provider. 42 U.S.C. 1395pp. Further, neither case directly and conclusively addressed the authority for use of sampling in assessing overpayments. It is noted that in Daytona Beach supra, the court found that use of a ten percent sample was a denial of due process. In the instant case, the sample is only eight and one tenth percent. Other cases cited by HCFA arise under other provisions of law, and do not refer to the necessary statutory authority to use sampling in assessing overpayments on Medicare Part A cases.

Established agency 'policy' cannot be considered determinative of correct procedure where it contravenes the law, i.e., statutes and regulations. Such is the case here, where a policy of use of sampling in Medicare Part A cases would preclude the notice and review provisions of the statute, 42 U.S.C. 1395pp.

A review of the citations of authority and background submitted by AVNS indicate that hearings under Title II procedures, including Medicare Part A appeals, are generally to be non-adversarial in nature, the agency not appearing by counsel, and its position being submitted on the established record. Thus, arguably, the agency does not have a right to appear. Notwithstanding the lack of a right of the agency to be heard, the Administrative Law Judge does have a duty to fully develop the record in order to make fully informed findings of fact, conclusions of law, and decisions. Pursuant to that duty, the Administrative Law Judge may make a party to the proceeding any person whose rights may be affected by the decision. 42 CFR 404.932(b). The hearing may be opened to the parties and any other persons the Administrative Law

Judge considers necessary and proper. 42 CFR 404.944. In the instant case, the undersigned has determined that participation by HCFA is necessary and proper to a full development of the facts upon which a decision may be rendered. The provider is in no way prejudiced by this procedure, as the ultimate decision on the specific cases before the undersigned will be based on the facts in evidence, and the provider will be afforded every opportunity to develop and present evidence and arguments, oral and written, as it so desires. 42 CFR 404.944, 949, 950(a), 953(a).

Harold Neufeld by

HAROLD NEUFELD
Administrative Law Judge

Date: July 1, 1985

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. Owen. Thank you, Mr. Chairman.

I am Jack Owen, executive vice president of the American Hospital Association. We represent about 6,100 hospitals and health care institutions.

I won't take a lot of time going over the testimony that I have already provided and some that has been talked about already, but I would like just to make a couple of comments, Senator.

First, as you know, the American Hospital Association continues to support the PPS Program and feels that it was the right way to go, and that the appeals mechanism is the next step in this process.

We have been concerned since the whole program was approved that it was approved rather quickly, and there were some issues of equity that must be looked at. And S. 1551 is an important first step in looking at these equity issues.

There have been no appeals procedure changes since 1972 under Medicare. And with the prospective pricing system, a complete change from a cost-reimbursement system, it is time to look at appeals. And this is the right start.

Neither beneficiaries nor providers are currently adequately protected by the system as it now stands.

We applaud the subcommittee for its consideration of this very important issue, especially you, Senators Heinz and Chafee, and Representative Ron Wyden in the House. It is a good first step.

Now, just a couple of comments, first on the part B appeals. We agree with you, Mr. Chairman, that these are currently being heard by insurance company representatives only. And even though Mr. Desmarais cites that 57 percent are reversed, it still is a question of who is hearing the appeals, and we think that should be changed.

S. 1551 would allow similar treatment for part B appeals as under part A appeals procedures: For claims over $500 and a hearing by an administrative law judge; for claims over $1,000, judicial review by courts would be available. And we think that is necessary. It's an American way of life.

Given the incentives of PPS to treat fewer patients in the inpatient setting and more in the outpatient setting, more treatment of Medicare patients is occurring outside of hospitals, and more claims are arising under part B. And we heard the testimony again from HCFA about the number of these outpatient visits. S. 1551 makes the process more responsive to part B, and it should be enacted.

Now, as far as provider representation of beneficiaries, that has traditionally been allowed. Most people who go into hospitals, who use doctors, expect that both the hospital and the doctor will look out for their interests; that has been a character and a feeling about hospitals and doctors since we have been in the system over the years. And yet, it was changed arbitrarily in 1984 by HCFA, with no notice or opportunity for public comment.

We think that the providers, the hospitals and the doctors, are more familiar with Medicare procedures, have well-established contacts in their social service departments and in their staffs. They deal with the fiscal intermediaries on a regular basis, and providers represent beneficiaries at no charge to the beneficiary.

The argument that providers' interests are in conflict? There is no real basis for this claim. In fact, HCFA has denied due process to the beneficiaries.

I would just say that we think this is a start. In our written testimony, beginning at page 7, there are some other appeal mechanisms in part A that we think need to be taken up next year, and we hope your committee will continue to do the good work it is doing.

Thank you.

Senator DURENBERGER. Very good.

Mr. Stutz.

[Mr. Owen's written testimony follows:]

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STATEMENT OF
THE AMERICAN HOSPITAL ASSOCIATION
BEFORE
THE SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON FINANCE
OF THE
UNITED STATES SENATE
ON S.1551
THE FAIR MEDICARE APPEALS ACT OF 1985

November 1, 1985

SUMMARY

The American Hospital Association (AHA) has demonstrated a continuing interest in the development and implementation of the Medicare prospective payment system (PPS) and particularly in the issues of adequacy and equity arising from that system. The issue of the sufficiency of existing appeals processes under Part A and Part B of Medicare is one of considerable significance to the Association, which has been involved with beneficiary and other provider groups to explore ways to improve the current system. The enactment of S.1551 would be an important first step by providing administrative hearings and judicial review for Part B claims, allowing the aggregation of claims, and restoring the recently-eliminated policy of permitting provider representation of beneficiaries on appeals. Other due process issues, not covered by S.1551 but considered important by the AHA, include: application of the Administrative Procedures Act; allowance of challenges to rulemaking actions; provider appeals of adverse Peer Review Organization determinations and technical coverage denials; appeals of PPS base-year cost determinations and PPS classifications; and Provider Reimbursement Review Board issues.

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, executive vice president of the American Hospital Association, which represents more than 6100 member hospitals and health care institutions and approximately 38,000 personal members. I am pleased to be here to address the need for review of the provider and beneficiary appeals provisions under Part A and Part B of the Medicare program, and, particularly, to comment on S.1551, the Fair Medicare Appeals Act of 1985.

As this Subcommittee is aware, the AHA has devoted considerable effort and attention to issues of adequacy and equity arising from the enactment of the Medicare prospective payment system and from the subsequent implementation of that system. These concerns extend beyond the specific applicability of PPS to inpatient hospital services to the impact of competitive reforms (and the federal budgetary pressures they are designed to address) across the Medicare program generally.

One of the most fundamental equity issues presented by the current administration of the Medicare program is the inadequacy of existing processes for beneficiaries and providers to obtain reconsideration of administrative actions which affect them and to appeal adverse results to impartial administrative bodies and the courts.

In the area of federal law, the Medicare statute imposes some of the most substantial restrictions on rights of appeal. In light of the impact of the

Medicare program on both beneficiaries and providers, these restrictions have been subjected to considerable criticism and to legal challenge. In the context of recent major changes and fiscal restraints imposed upon the program, the need for a legislative change in the appeals process has become a significant concern.

Congress' actions to restrict these rights of appeal in the early years of the Medicare program were based upon reasonable concerns that the program would be burdened in its infancy with a flood of litigation over small claims and minor administrative problems. As the program has matured, however, statutory restrictions have become a defensive shield behind which the Department of Health and Human Services (HHS) may act with impunity in policymaking and avoid the resolution of major administrative issues and claims of a recurrent nature. In some cases, as a result, important problems for beneficiaries and providers have gone unresolved. In other cases, extensive and duplicative litigation has been required to resolve issues that might have been resolved more expeditiously and less expensively had more liberal appeals processes existed in the first instance.

The AHA has worked extensively with a coalition of provider and beneficiary organizations, led by the Catholic Health Association and the National Senior Citizens Law Center, to explore a wide range of potential improvements in the Medicare appeals process. S.1551 responds to certain recommendations made by this coalition, and this Subcommittee is to be highly commended for its expeditious consideration of this bill. The AHA believes that S.1551 would be an important first step in resolving equity issues related to the Medicare appeals process. As we discuss elsewhere in these comments, we also believe a number of other fair appeals issues are worthy of consideration and action by the Congress.

COMMENTS ON S.1551

S.1551 would expand the rights of beneficiaries to appeal Medicare claims denials by providing to Part B claimants the same avenues of administrative hearing and judicial review now provided to Part A claimants (provided that the amount in controversy exceeds $500); by permitting such claims to be aggregated for purposes of appeal; and by restoring the beneficiary's right to be represented in a hearing by a health care provider, a right abrogated administratively by HHS in 1984. The AHA strongly supports all three of these provisions.

Present law provides a "fair hearing" to beneficiaries on Part B claims amounting solely to a reconsideration by the Part B carrier. If the reconsideration is adverse to the beneficiary, no further recourse is available. This process is inequitable inasmuch as the person hearing the appeal on behalf of the carrier frequently stands in a supervisory or other relationship to the individual who denied the claim in the first instance. Moreover, the original rationale for limiting review of Part B claims, namely that such claims were too inconsequential to justify more extensive hearings, does not now apply in light of the greater number and sophistication of procedures performed in the outpatient setting.

It is likewise appropriate to permit claims involving similar services or common issues of law and fact to be aggregated for purposes of appeal. The fact that a particular claim is small in amount does not mean that it is without merit or that it is not an important matter for a large number of beneficiaries. In this regard, S.1551 would ensure that such "smaller" matters could be heard on appeal beyond the carrier's reconsideration, and that the courts ultimately would be able to review Medicare program determinations in matters of potentially broad consequence to the beneficiary population. Judicial economy also would be well served by permitting group appeals under Part B.

Finally, provider representation of beneficiaries in appeals is a critical issue, and AHA strongly supports congressional action to redress HHS' short-sighted repeal of this beneficiary right. In January 1984, the Health Care Financing Administration (HCFA) issued simultaneous revisions to its hospital, home health agency, skilled nursing facility, and intermediary manuals, prohibiting providers from serving as beneficiaries' representatives in appeals of adverse coverage determinations. No notification or opportunity to comment was provided to the public.

From the beginning of the Medicare program, providers routinely gave assistance to beneficiaries in filing their claims, and made use of ongoing contacts with intermediaries to obtain explanations of eligibility and coverage determinations and to correct errors. When necessary, providers also assisted in formal administrative appeals.

In reversing previous policy, HCFA argued that providers, by representing beneficiaries, actually obtained an avenue of appeal for themselves otherwise unavailable under the Medicare Act. HCFA also argued that providers interests are, in most cases, in conflict with those of the beneficiaries. These arguments are disingenuous. Limitations on provider appeals contained in the Medicare Act are not intended to preclude a provider from speaking on behalf of a beneficiary where the beneficiary freely elects such representation. Moreover, a hearing officer will properly exclude any evidence or arguments not germane to the beneficiary's claim. The fact that a provider may incidentally benefit in certain cases (e.g., those involving waiver of liability) where the beneficiary prevails is clearly secondary to the public benefits obtained by clarification of coverage policies through appeal.

The hypothetical "conflicts" described by HCFA in 1984 are likewise suspect. HCFA argues that if a provider is shown to be without fault in rendering non-covered services, the beneficiary can, in some cases, be assessed for an overpayment and that, conversely, if the provider is at fault, it can be required to refund payments made by the beneficiary. In the first case, no appeal will occur because the beneficiary has received payment. In the second, the hearing officer has authority under existing law to disqualify the provider as representative.

As a practical matter, elderly and infirm Medicare beneficiaries are not sufficiently knowledgeable about the Medicare appeals process to exercise their rights effectively without assistance, and many cannot afford to hire a lawyer for such purpose. The real effect of HCFA's 1984 policy change is to cut off beneficiary appeals and thereby reduce the Medicare program's potential liability for payment of proper claims. This denial of due process would be corrected appropriately by S.1551.

OTHER APPEALS ISSUES

Beyond those matters addressed by S.1551, a number of important due process issues remain in the administration of the Medicare program. For purposes of this statement, we will simply highlight the problems. We would be pleased to provide additional information and specific recommendations for amendments at the Subcommittee's request.

Application of Administrative Procedure Act (APA) Standards

In many of the current administrative appeals processes, the arbiter is bound by manuals or program instructions that never have been subject to the public comment process of the APA. Also, HHS has consciously used informal agency communications processes to avoid APA requirements. The AHA believes the Secretary should be bound to APA standards by law, not by voluntary compliance. Moreover, administrative tribunals should be bound only to the statutes and to regulations issued in accordance with the APA.

Challenges To Rulemaking Actions

Under current law, any challenge to a regulation that remotely entails a claim for payment (presently or in the future) cannot be made directly in court but must follow a time-consuming process of exhausting administrative remedies. This is true even if the challenge involves only a question of law which the administrative bodies cannot decide. Moreover, provider organizations such as the AHA, which might otherwise assert a single claim on behalf of all hospitals, are barred completely from litigating these matters.

HHS has used this situation to operate under regulations later determined to be unlawful for as long as seven years before the administrative and judicial processes are exhausted. HHS has adopted a non-acquiescence policy by which judgments adverse to the Department are recognized only as to the particular claimants in the litigation, even if a reviewing court has held the underlying regulation illegal. The HHS strategy has undercut the original Congressional intent behind limiting judicial review by fostering duplicative claims and litigation rather than expedient administrative settlement.

Congressional action is necessary to provide appropriate access to the courts, thereby enforcing accountability on the Department. This need is particularly acute in the context of the prospective payment system, where prospective rate-setting requires rapid adjudication of legal issues and where the Department has been less than fully observant of rulemaking standards.

Provider Appeals of Adverse Peer Review Organization (PRO) Determinations Not Paid under Waiver of Liability

Under the current PRO appeals process, providers may appeal only the question of whether they knew, or should have known, that a particular service was not covered by Medicare. They are not permitted to appeal the merits of the issues involved in the claim, a right which is reserved solely to the beneficiary. Inasmuch as the beneficiary seldom has any financial risk in such cases, the present situation is a denial of due process to providers.

PRO Reconsideration Process

PROs are required to provide a reconsideration upon request of any final determination adverse to a beneficiary, provider, or practitioner. There are no standards for such reconsiderations, and many PROs have refused to implement a process that comports with accepted notions of due process. Specific statutory standards for reconsiderations would alleviate this problem.

Provider Appeals of Technical Coverage Denials

Providers of home health services have had particular problems stemming from the fact that terms such as "homebound," "intermittent," and "skilled nursing" are subject to multiple interpretations. Under current law, home health agencies must absorb the costs of services when coverage is denied on the basis of such technical interpretations, without recourse. Fairness to providers and beneficiaries requires that a means of direct appeal be created, by which program standards could be more clearly defined.

Final Determinations for PPS Base-Year Costs

HCFA has taken the position, through its Ruling 84-1, that an intermediary's determination of base-year costs for purposes of establishing PPS payment rates are not a "final determination" subject to review by the PRRB and the courts. Reviewing courts have disagreed unanimously with this policy but, as yet, HCFA has refused to modify it. This matter could be corrected expeditiously through legislative action.

PPS Classifications

At present, there is no specific mechanism for a provider to request a special classification or payment adjustment under PPS (e.g., as a referral center or provider of excluded services) or to challenge an adverse initial determination. This has become a significant problem which could be resolved effectively through legislation.

Retroactivity and Appeals Generally Under PPS

Present law prohibits judicial review of HHS determinations concerning DRG classifications, the weighting factors assigned to such classifications. The Secretary has unlimited discretion in these matters. A check on this power, in the form of judicial review, is necessary to keep the system in balance. However, the relief to be provided by the courts in such cases could appropriately be limited to prospective application.

Provider Reimbursement Review Board (PRRB) Issues

Congress intended that the PRRB would afford health care providers a forum for impartial, expert, and generally final administrative review of Medicare payment issues. In recent years, the Secretary has increasingly exercised the prerogative to reverse PRRB decisions favoring providers, reducing the provider rate of success in administrative appeals to less than 20 percent of all cases. Moreover, the Department's supervision of PRRB (through regulation) has eroded the board's credibility to the point that it is now largely viewed as a way station on the road to the courts. The time has come for Congress to make the PRRB truly independent of the Secretary, thereby restoring the credibility of its processes and reducing the necessity of litigation over Medicare program issues.

In addition, two other statutory actions are needed to preserve the original intent of the PRRB appeals process. First, the board must be directed by law to extend the time for filing of appeals in cases of good cause, a problem which currently exists as a result of the Department's insistence on rigid adherence to statutory time limits. Providers have had difficulty obtaining review in cases where these deadlines have been missed due to circumstances beyond a provider's reasonable control. Second, the PRRB should be required by law to render findings of fact in all decisions. Such a requirement would clarify board rulings for other providers and promote judicial efficiency in cases where court review is sought.

Beneficiary Appeals of Prospective Coverage Determinations

Despite the objections of providers and beneficiaries, current HHS rules governing PPS and the PRO review process create a substantial incentive to deny admission to a hospital in cases where coverage or payment are in doubt. To strike a fair balance in this process, beneficiaries should be provided an opportunity to obtain an expedited review of that determination by a PRO or fiscal intermediary.

CONCLUSION

The AHA commends this Subcommittee for its interest in reviewing the provider and beneficiary appeals processes under Part A and Part B of the Medicare program, and especially for its consideration of S.1551, the Fair Medicare Appeals Act of 1985. S.1551 would expand the rights of Medicare beneficiaries to appeal claims denials and would permit providers to represent beneficiaries on appeal, a right administratively abrogated by HHS in 1984. Beyond S.1551, a series of Medicare due process issues remian unresolved. The AHA is willing to work with this Subcommittee to provide specific legislative recommendations for further amendments to the Medicare appeals processes.

STATEMENT OF ROBERT STUTZ, VICE PRESIDENT AND GENERAL DIRECTOR, WILLOWCREST BAMBERGER, DIVISION OF THE ALBERT EINSTEIN MEDICAL CENTER, PHILADELPHIA, PA, ON BEHALF OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. STUTZ. Good morning.

Senator DURENBERGER. Good morning.

Mr. STUTZ. I am Robert Stutz, vice president and general director of the Willowcrest-Bamberger Division of the Albert Einstein Medical Center in Philadelphia. We are a hospital based skilled-nursing facility with 102 Medicare-certified beds. We did have almost 102 patients, but as of today we have half of our building in disuse; part of the reasons for that is what your bill, S. 1551, is going to address, I hope.

Prior to September 1984, we had an average of 33,000 annual Medicare SNF patient-days. Currently, due to factors related to HCFA and our fiscal intermediary, the number of annual Medicare-days has declined to about 18,000.

I appreciate the opportunity to testify today on behalf of the American Association of Homes for the Aging, a national nonprofit organization representing approximately 2,700 nonprofit homes, housing, health-related facilities, and community services for the elderly.

AAHA is very supportive of efforts to improve the current Medicare appeals system under which beneficiaries are often denied their rights to due process, and unfair claims denials often are not appealed.

I will briefly cite several of these systematic inequities and will recommend solutions for improving the process:

Currently, Medicare part B beneficiaries have very limited appeal rights. Unlike Medicare part A beneficiaries, their appeals of part B coverage denials are limited to review within the context of the carrier, with no right to appeal to an impartial party. AAHA believes that denying the beneficiary such an impartial review by the courts constitutes a denial of his or her due-process rights.

AAHA is very supportive of S. 1551, introduced by Senators Durenberger, Heinz, and Chafee, which would address this problem by extending appellate rights to individuals denied benefits under part B. The bill would also address an extremely important problem—specifically, provider representation of beneficiaries at both part A and part B appeals. Currently, beneficiaries too often cannot afford a private attorney to appeal their case, and legal services are hard-pressed to increase their caseloads under present budget constraints. Therefore, providers would often be in the most feasible position to represent beneficiaries in the appeals process.

Typically, providers are very familiar with the facts involved, understand the patient's medical condition and service needs, have a great deal of experience with Medicare coverage criteria, and have an incentive to represent beneficiaries effectively, because providers often face nonpayment when a Medicare claim is denied.

Provider representation in beneficiary appeals is a needed option, since the lack of adequate representation in appeals has forced many older Americans to impoverish themselves by paying for services that should be covered by Medicare.

Although S. 1551 addresses the problems with part B appeals and provider representation of beneficiaries, it fails to include remedies for serious problems that Medicare beneficiaries have with the part A skilled nursing facility coverage and appeals process. A large number of beneficiaries are being denied Medicare SNF coverage unfairly, because procedures have a clear bias against coverage of these services.

Allow me to highlight three problems related to the Medicare SNF claims and appeals:

First, under the current Medicare waiver of liability, providers are very reluctant to submit all but the most clearly covered claims. This is no easy task, however, because the decisions by the fiscal intermediaries are very inconsistent. Moreover, I share the experience with other Medicare SNF providers that in the last year a marked change has occurred, whereby HCFA and fiscal intermediaries are applying the coverage criteria much more stringently and denying claims that used to be covered.

Thus, it is extremely difficult for providers to tell whether a claim will be covered or not. If the provider does submit the claim in good faith, but it is denied by the fiscal intermediary, the provider must take a loss and is not permitted to seek payment from the beneficiary. Therefore, providers have a clear incentive to avoid putting their facilities at risk, and instead to charge potentially Medicare-eligible patients the private rate without submitting the claim. AAHA believes it is clear that the waiver of liability provisions operate to discourage the submission of potentially meritorious claims, thereby serving to deny Medicare coverage to beneficiaries.

As a solution to this problem, AAHA first urges that, at a minimum, fiscal intermediaries be required to specify the reason for denial of a claim. Without a stated reason, providers have difficulty explaining the denial to the beneficiary and have no basis for evaluating whether the next claim submitted will fall prey to the same denial.

More broadly, AAHA believes that all potentially covered Medicare claims should be required to be submitted for coverage without provider liability for noncoverage. Providers must be taken out of the guessing game and not be held liable for any claims submitted.

The next step in improving the process is to reform the appeals provisions for beneficiaries.

Senator DURENBERGER. The next step is to end your statement.

Mr. STUTZ. All right.

Senator DURENBERGER. AAHA. [Laughter.]

Mr. STUTZ. Can I just sum up?

Senator DURENBERGER. You did. The whole statement is a summary.

Mr. STUTZ. Just 1 second.

Finally, there are a few instances where beneficiaries do pursue the entire scope of their appeal rights and appeal their cases to the administrative law judge, and then to the Federal district court. Unfortunately, this time-consuming and potentially costly effort applies only to the specific case, as favorable decisions at these levels have no effect on future cases—that is, the administrative law judge decision is not binding on future factually identical cases and has no precedential value whatsoever.

I'll stop there. Thank you.

Senator DURENBERGER. Thank you. Frances Steele.

[Mr. Stutz's written testimony follows:]

TESTIMONY OF

ROBERT STUTZ
Vice President and General Director
Willow-crest Bamberger Division of Albert Einstein Medical Center
Philadelphia, Pennsylvania

on behalf of the
AMERICAN ASSOCIATION OF HOMES FOR THE AGING

on the
MEDICARE APPEALS PROCESS

before the
SENATE FINANCE COMMITTEE'S
HEALTH SUBCOMMITTEE

November 1, 1985

SUMMARY OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING'S TESTIMONY ON THE MEDICARE APPEALS PROCESS BEFORE THE SENATE FINANCE COMMITTEE'S HEALTH SUBCOMMITTEE, NOVEMBER 1, 1985

- AAHA strongly supports the provisions of S.1551, which would improve the appeals rights for Medicare Part B beneficiaries and permit providers to represent beneficiaries at both Part A and Part B appeals.

- AAHA urges the Subcommittee to take a close look at the particular appeals problems experienced by beneficiaries under the Medicare Part A skilled nursing facility benefit. First, because the Medicare waiver of liability provisions operate to deny coverage to beneficiaries, all Medicare claims should be required to be submitted for coverage, without provider liability for noncoverage. Second, statutory attorneys fees' provisions should be extended to lawyers for representing beneficiaries in Medicare appeals under the Equal Access to Justice Act. Currently, only 0.3 percent of claims are appealed to the reconsideration level of the process. Third, federal district court decisions should be given precedential value for future cases so that ALJs and FIs cannot ignore these determinations. This policy of non-acquiescence is unfair and inconsistent with normal judicial procedures.

- In order to improve access to the SNF Medicare program, AAHA strongly supports the creation of a system with prior authorization of claims.

- Because the new hospital DRG prospective payment system creates an incentive to discharge Medicare patients earlier than in the past, AAHA supports development and adoption of legislation which would require that written notice be given to every Medicare patient 48 hours prior to being discharged from the hospital. The notice should contain information as to why the patient is being discharged and should also include information on how to initiate an expedited appeal.

- Home health agencies should be permitted to directly appeal "technical denials" of claims. The current system is unfair because these denials are currently appealable only by the beneficiary and are not subject to the provider waiver of liability provisions.

I am Robert Stutz, Vice President and General Director of the Willowcrest-Bamberger Division of the Albert Einstein Medical Center in Philadelphia, Pennsylvania. We are a hospital-based skilled nursing facility, with 102 Medicare certified beds. Prior to September 1984, we had an average of 33,000 annual Medicare SNF patient days. Currently, due to factors related to our fiscal intermediary (FI), the number of annual Medicare patient days has declined to about 18,000.

I am testifying today on behalf of the American Association of Homes for the Aging (AAHA). AAHA is a national nonprofit organization, representing approximately 2,700 nonprofit homes, housing, health-related facilities and community services for the elderly. We very much appreciate this opportunity to testify before the Senate Finance Committee's Health Subcommittee on the problems with the Medicare appeals process.

The American Association of Homes for the Aging is very supportive of efforts to improve the Medicare appeals system. Under the current system, beneficiaries are often denied their right to due process for receiving the services provided under the program. Unfair claims denials often are not appealed, or are not even permitted to be appealed. Even when an appeal is undertaken, it is reviewed by parties with a clear bias towards restrictions on service coverage and delivery. The appeals system has an overriding concern with cost containment, as beneficiaries are not informed of their right to appeal, barriers are created to prevent appeals, and the process is rigged to deny coverage unfairly. Our comments shall look at several of these systemic inequities and will recommend solutions for improving the process.

APPEALS UNDER MEDICARE PART B

Currently, Medicare Part B beneficiaries have very limited appeal rights. Unlike Medicare Part A beneficiaries, their appeals of Part B coverage denials are limited to review by the fiscal intermediary (FI). If over $100.00 is in dispute, a hearing officer — employed by the FI which makes the initial coverage determination and reconsiders its own decision — reviews the claim, with no right to appeal to an impartial party. AAHA believes that denying the beneficiary such an impartial review by the courts constitutes a denial of his or her due process rights. This unfair procedure under Medicare Part B affects not only physician visits, but other Part B covered services such as outpatient procedures, medical home health care, and durable medical equipment. With the onset of the new Medicare hospital DRG perspective payment system, these services have become increasingly important to beneficiaries, as evidence increasingly indicates that hospitals are discharging patients more quickly with more intensive post-hospital care needs.

AAHA is very supportive of S. 1551, introduced by Senators Durenberger, Heinz and Chafee, which would address this problem by extending appellate rights to individuals denied benefits under Part B. Under the legislation, disputes concerning claims of between $500 and $1000 could be appealed to an administrative law judge (ALJ) while disputes greater than $1000 could be appealed to the courts. The bill would also address an extremely important problem, specifically, provider representation of beneficiaries at both Part A and Part B appeals. Currently, beneficiaries too often can not afford a private attorney to appeal their case, and legal services are hard-pressed to increase their caseloads under present budget constraints. Therefore, providers would often be in the most feasible position to represent beneficiaries in the appeals process.

Typically, providers are very familiar with the facts involved, understand the patients' medical condition and service needs, and have a great deal of experience with Medicare coverage criteria. Providers have an incentive to represent beneficiaries effectively because the alternative payment mechanism for them is most likely to involve a lower Medicaid rate, collection problems, or nonpayment. In addition, provider problems with the Medicare waiver of liability rules are making them more anxious to get Medicare coverage for their patients. Provider representation in beneficiary appeals is a needed *option*, since patients who can afford private legal representation usually will not need the providers' assistance in appealing adverse determinations and since not all providers would be able to undertake the usually lengthy appeals process. The lack of adequate representation in appeals has forced many older Americans to impoverish themselves by paying for services that should be covered by Medicare. Permitting providers to represent beneficiaries will help end this form of discrimination and make the Medicare program function as Congress intended. We strongly urge the passage of S. 1551 so that these unfair rules will be eliminated.

MEDICARE APPEALS AND SKILLED NURSING FACILITIES

Although S. 1551 addresses the problems with Part B appeals and provider representation of beneficiaries, it fails to include remedies for serious problems that Medicare beneficiaries have with the Part A skilled nursing facility (SNF) coverage and appeals process. A large number of beneficiaries are being denied Medicare SNF coverage unfairly because procedures have a clear bias against coverage of these services. Three problems will be discussed in turn: the operation of the Medicare waiver of lia[illegible]ty, the lack of legal representation for beneficiaries, and the problem of FI and ALJ not being required to follow court decisions.

Under the current Medicare waiver of liability, if less than 5 percent of claims submitted for coverage by a Medicare SNF provider are denied, a presumption will exist that the provider submitted claims in good faith and could not have reasonably known that they would not be covered; therefore, the provider is not liable for the homes' FI coverage denials. But because of this low 5 percent threshold, and because HCFA has proposed rules that would eliminate completely the waiver presumption, providers are very reluctant to submit all but the most clearly covered claims. This is no easy task, however, because the decisions by the fiscal intermediaries are very inconsistent; thus, it is extremely difficult for providers to tell whether a claim will be covered or not. If the provider does submit the claim in good faith, but it is denied by the FI, the provider must take a loss and is not permitted to seek payment from the beneficiary. Therefore, providers have a clear incentive to avoid putting their facilities at risk and, instead, to charge potentially Medicare eligible patients the private rate without submitting the claim. AAHA believes it is clear that the waiver of liability provisions operate to discourage the submission of potentially meritorious claims, thereby serving to deny Medicare coverage to beneficiaries.

As a solution to this problem, AAHA believes that all potentially covered Medicare claims should be required to be submitted for coverage, without provider liability for noncoverage. Providers must be taken out of this "guessing game" and should not be held liable for any claims submitted. Such liability provisions have no precedent. Existing disincentives for claims submission must be eliminated by sending all Medicare claims to the FI, as currently done in New York state. Claims denied after a full opportunity for appeal should be paid by Medicaid where eligibility exists or by the patient, not taken as a loss by the provider.

The next step in improving the process is to reform the appeals provisions for beneficiaries. If a claim is denied, beneficiaries should be able to appeal the claim fully before possibly needing to assume any private pay responsibility. Currently, only 0.3 percent of claims submitted go through the FI reconsideration step in the appeals process. Far fewer claims are appealed to the ALJ or to the federal district court. The reason for this problem is, first, the inability of providers to represent beneficiaries as discussed above and, second, the absence of statutory attorneys' fees provisions to provide compensation for lawyers to represent beneficiaries in appeals. Just as attorneys' fees are provided for representation in Title VII cases under the Equal Access to Justice Act, we recommend that legal representation for beneficiary Medicare appeals cases be similarly covered under this Act. By making a modest fee available, we believe there will be a needed increase in representation by private and legal aid attorneys for beneficiary appeals. As long as so few beneficiaries are able to appeal adverse coverage determinations, FIs will continue to be encouraged to deny coverage, as they know their decision is unlikely to be challenged and overturned. Statutory provisions for attorneys' fees, in combination with permitting providers to represent beneficiaries in coverage denial appeals, will significantly help to ensure that the appeals process will be a reality, not just a concept, and that older Americans will not be forced to pay out-of-pocket for care to which they are entitled under Medicare.

Finally, there are a few instances where beneficiaries do pursue the entire scope of their appeals rights and appeal their cases to an ALJ and then to the federal district court. Unfortunately, this time consuming and potentially costly effort applies only to the specific case, as favorable decisions at these levels have no affect on future cases. That is, ALJ and federal district court decisions in Medicare appeals cases have no precedential value whatsoever. Therefore, as currently occurs, on one day a federal district court can decide there is Medicare SNF coverage in a beneficiary appeal and the next day, a FI can review a factually identical case, ignore the court decision and deny coverage. This situation is similar to what occurred with social security disability determinations, where this policy of "non-acquiescence" has operated to deny coverage unfairly. It also runs counter to our American legal system. In our legal system, when a factually identical case has already been decided by a higher court, the lower court must follow the higher courts' decision in subsequent cases. Without the concept of precedent, Supreme Court decisions, for instance, would apply only to the cases this court actually decides; lower courts could ignore the decisions made by courts above them, and thus, judicial decisions could be grossly inconsistent. The concept of precedent is critical to the fair and consistent operation of our judicial system. We strongly recommend that this concept be extended to apply to Medicare coverage determination appeals. By requiring FIs and ALJs to follow determinations made by the courts when these lower level bodies review identical cases appealed subsequently, the consistency of appeals decisions will increase, the number of unfair denials will be reduced, and the necessity and burden of pursuing the full appeals process through the federal district court level should be lessened.

In addition to the needed improvements in the Medicare appeals process, AAHA believes that a broader approach to address Medicare SNF access problems is needed. The best method for improving the SNF Medicare coverage process would be a system which provides prior authorization of coverage. Used in many state Medicaid plans, while the beneficiary is still in the hospital, the provider would be informed by the FI before SNF admission as to whether a person would get some Medicare SNF coverage. A federal law permitting such a system was in place several years ago (see attached) but was repealed for no apparent reason. AAHA urges the Senate Finance Subcommittee on Health to take a close look at reinstating a system which permits prior authorization of claims.

EARLY HOSPITAL DISCHARGES

Because the new hospital DRG prospective payment system creates an incentive to reduce hospital length of stay for Medicare beneficiaries, patients are being discharged earlier than in the past. There are reports that some of these discharges are premature and may be inappropriate. It has been alleged that some patients have been told that their Medicare payments have "run-out" and that they must, therefore, leave the hospital. To protect beneficiaries from inappropriate discharges, AAHA supports adopting a provision which would require that written notice be given to every Medicare patient 48 hours prior to being discharged from the hospital, and that the notice contain information as to why he/she is being discharged. Since many beneficiaries do not know of the appeal rights that are available to them, the notice should also include information on how to receive an expedited appeal from the Peer Review Organization (PRO). The notification of the availability of the expedited appeal will help in eliminating inappropriate discharges. Absent the expedited appeal provision, it is likely that any wrongful discharge would be discovered only weeks after the person has already left the hospital.

HOME HEALTH PROVIDER APPEALS OF "TECHNICAL DENIALS"

We understand that HCFA has a policy that it refers to as "technical denials" of home health agency (HHA) visits. FIs make such denials when they determine that the home health visit failed to meet statutory or regulatory requirements, other than medical necessity. For instance, these technical denials may be for failure to meet "homebound" requirements or failure to meet "in need of intermittent skilled nursing care" standards. These denials are appealable only by the beneficiary and are not subject to provider waiver of liability provisions. This system creates financial hardships for HHAs, because the costs for providing such services must be absorbed by the provider, who cannot appeal the decision and cannot be paid under the waiver of liability provisions.

AAHA recommends that statutory language be developed to permit HHAs to directly appeal these technical denials. Such provider appeals rights should only be permitted to be exercised in those cases when a beneficiary chooses not to appeal on his or her own behalf. There is no good reason why the interpretation of such ambiguous terms as "homebound" and "intermittent" should not be open to review, particularly in light of the fact that there is a great deal of inconsistency in how FIs interpret these terms. This problem of interpretation has been recognized and addressed by Senator Heinz who has introduced legislation, S.778, which seeks to clarify the definition of intermittent care.

CONCLUSION

Again, AAHA urges adoption of S.1551 as well as development of additional legislation to address the coverage and appeals problems AAHA has identified in the Medicare Part A SNF and home health benefits. We commend the Subcommittee for holding this hearing and thank you for the opportunity to present our views.

STATEMENT OF FRANCES STEELE, EXECUTIVE DIRECTOR, HOME HEALTH AGENCY MULTICOUNTY, HATTIESBURG, MS; ON BEHALF OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

Ms. STEELE. Mr. Chairman, my name is Frances Steele. I am the executive director of Home Health Agency Multicounty, in Hattiesburg, MS. I am here today as the representative of the American Federation of Home Health Agencies. I am very pleased to have this opportunity to present testimony to the Senate Finance Committee on the issue of Medicare appeals.

This is an issue which has brought together a broad coalition of providers, consumers, and senior citizens' groups.

Current HCFA policy prohibits providers from representing beneficiaries in the appeals process. This policy violates the intent of Congress and deprives Medicare recipients of benefits to which they are entitled.

HCFA's prohibition is part of a pattern of policies developed recently to cut costs at the expense of quality and access to care. We urge that this problem be remedied by passage of Senate 1551, the Fair Medicare Appeals Act of 1985, introduced by you, Senator, or inclusion of the provisions of the bill in the Omnibus Budget Reconciliation Act during conference between the House and the Senate.

We have looked at Medicare law and regulations, and we can find nothing that precludes provider representation of the beneficiary. It appears that HCFA decided upon the result they wished to achieve, then looked around for words to justify the end.

We believe that HCFA's prohibition was precipitated by the success of providers representing beneficiaries. Those with the most knowledge of the case and the process are banned because they have demonstrated their effectiveness. Who could be more qualified to represent a beneficiary than an employee of a home health agency who has provided care to the patient, is familiar with the details of the case, and has experience with the appeals process?

Many patients receiving denials are extremely sick and confused. Often, they live alone or with a spouse who is equally debilitated. Even if there are competent family members or friends available and willing to assist, the process is extremely confusing to a lay person with no appeals experience.

To pursue an appeal, beneficiaries face a formidable task of filling out the proper forms in a timely manner, developing arguments to contest the denials, and collecting evidence to support the case. A beneficiary can turn to a lawyer for assistance, but few debilitated patients can afford the services of a private attorney. My own agency has had to train lawyers from legal services to enable them to represent my patients. My nurses prepare the documentation and train the lawyers, too.

And another thing that really bothers me is that, when at the ALJ hearing stage, the ALJ's intimidate patients and families that have been instructed they must appear by telling them that they can reverse the waiver that has been applied to this case if they rule against them.

These people have a third-grade educational level; they don't know what "waiver" means. And it is really intimidating to them to get to the hearing and have this occur.

The ban on representation coincides with an upsurge in denials and HCFA's requirement that intermediaries find $5 in denials for every $1 they receive for medical review.

And while intermediaries are pressured to produce denials, they are not penalized for their own errors.

The upsurge in denials in my own agency began with my fiscal intermediary entering the competition for selection as one of the 10 regional intermediaries. I have seen my own patients intimidated in what clearly is an attempt to prevent them from exercising their right to appeal.

HCFA's Atlanta regional office has sent a form, which I have submitted—this form—with my testimony, to a number of beneficiaries who have appealed denials. A form of this type coming from the Government carries the implication that something is wrong. Beneficiaries are fearful that they will lose their Medicare benefit and their Social Security payment if they answer incorrectly.

Some patients have been contacted personally by the Office of Hearings and Appeals in Atlanta, and led to believe that they must appear in person to pursue their appeals, when there is no such requirement.

In one case, a beneficiary was visited by a woman who stated she was from the Social Security Office and advised to sign a form requesting that her Medicare hearing be dismissed. She was afraid that her Social Security checks would terminate if she did not comply.

It is not right for the system to be so skewed against the beneficiary. To return balance to the process, we urge prompt enactment of Senate 1551 and an exploration of the intertwining issues of denial quotas and fiscal intermediary performance. This would help focus the Medicare Program back on provision of quality health care to elderly and disabled Americans, the purpose for which it was instituted.

Thank you for the opportunity to present our testimony to you today.

Senator DURENBERGER. Thank you very much.

[Ms. Steele's written testimony follows:]

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
1320 Fenwick Lane • Suite 500 • Silver Spring, Md. 20910 • (301) 588-1454

STATEMENT

OF THE

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

ON

MEDICARE APPEALS

BEFORE THE

SENATE FINANCE HEALTH SUBCOMMITTEE

NOVEMBER 1, 1985

PRESENTED BY

FRANCES STEELE

SUMMARY

HCFA policy prohibits providers from representing beneficiaries in the appeals process. This policy violates the intent of Congress and deprives Medicare recipients of benefits to which they are entitled. This prohibition is part of a pattern of policies implemented by HCFA to cut costs at the expense of quality and access to care.

Many patients receiving denials are extremely ill and confused; often they live alone or with a equally debilitated spouse. Even if there are others willing to assist in the appeal, the process is very intimidating.

A successful appeal benefits both the provider and the beneficiary, enabling the provider to retain waiver of liability and the patient to continue receiving services that would otherwise be disallowed. There is therefore no conflict between the interests of the two, as HCFA contends.

No one is more qualified to represent a beneficiary than an employee of an HHA who is familiar with the details of the case and has experience with the appeals process. We believe that HCFA's prohibition was precipitated by the success of providers representing beneficiaries in the appeals process. Those with the most knowledge of the case and the process are banned because they have demonstrated their effectiveness.

The ban on representation coincides with an upsurge in denials, intermediary competition to be selected as a regional intermediary, and HCFA's requirement that FIs recover $5 in denials for every $1 received for medical review. While FIs are pressured to produce denials, they are not penalized for their own errors. At the same time that HCFA is encouraging denials, beneficiaries are left without the representation of their most effective advocates in mounting appeals.

We urge passage of the Fair Medicare Appeals Act (S.1551) and an exploration of the related issues of denial quotas and fiscal intermediary performance as a remedy.

Mr. Chairman, my name is Frances Steele. I am the Executive Director of Home Health Agency Multi County, in Hattiesburg, Mississippi. I am here today as the representative of the American Federation of Home Health Agencies. I am very pleased to have this opportunity to present testimony to the Senate Finance Committee on the issue of Medicare appeals.

From the inception of the Medicare program, health care providers served as representatives of the beneficiary in the appeals process. In January, 1984, however, the Health Care Financing Administration issued a directive prohibiting providers or their employees from representing beneficiaries whose services have been denied. We believe that this HCFA policy is based on spurious reasoning, violates the intent of Congress, and serves to deprive elderly and disabled Americans of benefits to which they are entitled.

We urge that this problem be remedied by passage of S.1551, the Fair Medicare Appeals Act of 1985, introduced by Senators Durenberger, Heinz, and Chafee, or inclusion of the provisions of the bill in the Omnibus Budget Reconciliation Act during conference between House and Senate.

We believe that the prohibition against provider representation of beneficiaries is but one piece of a whole pattern of policies implemented by HCFA to cut costs, at the expense of quality and access to care. The bottom line has become the only line.

We have looked at Medicare law and regulations and we can find nothing that precludes provider representation of the beneficiary in the appeals process. (Reference Sec.206(a) and 1879(d) of the Social Security Act and Social Security regulations at 20 CFR 404.1705(b), 404.1707, and 404.1710.) Let me call your attention to 404.1705 in particular. This section describes who may be appointed as a representative for hearings and appeals, and states that a person who is not an attorney may be designated if he or she is of good character and reputation; is capable of giving valuable help; is not disqualified from acting as a representative; and is not prohibited by law from acting as a representative.

We have raised these points with HCFA and have been told: "We believe there is sufficient authority in the statute, regulations, and formal program instructions to deny an HHA the right to represent a beneficiary in pursuing an appeal under the Medicare program."

In precluding provider representation, it appears that HCFA officials decided upon the result they wished to achieve, then looked around for words to justify the end. The result is HCFA's contorted justification, as found in Revision 1079 of the Fiscal Intermediary Manual (HIM-13). I would like to quote several of their arguments and then respond.

> "HCFA is concerned that permitting providers to act as the beneficiary's representative is of dubious value to the beneficiary because the provider cannot act as a qualified representative."

Who could be more qualified to represent a beneficiary than an employee of an HHA who has rendered care to the patient, is familiar with the details of the case, and has experience with the appeals process? Many patients receiving denials are extremely ill and confused; often the beneficiary lives alone or with a spouse equally debilitated. Even if there are competent family members or friends available and willing to assist in the appeal, the process is daunting to a layperson with no appeals experience. To pursue an appeal, beneficiaries face the formidable tasks of filling out the proper forms in a timely manner, developing arguments to contest the denial, and collecting evidence to support the case. In the absence of representation by family, friends, or HHA personnel, a beneficiary could turn to a lawyer; however few debilitated beneficiaries can afford the services of a private attorney. My own agency has had to train lawyers from Legal Services to enable them to represent my patients. We prepare all the documentation and provide witnesses. My nurses have to prepare the case and train the lawyers too.

> "There is a question of a conflict of interest between a provider and a beneficiary because of the provider's interest in protecting its favorable waiver of liability presumption or appealing a coverage determination."

The facts are quite the opposite. Beneficiaries are never harmed by a successful appeal which allows them to continue to receive services. There is no conflict between the interest of the provider and the interest of the beneficiary in appealing a denial. If a provider is successful and is therefore able to retain waiver of liability, the provider benefits; the patient equally benefits since by reversing the denial, the HHA is able to continue services that would otherwise be disallowed. If an HHA does not encourage a patient to contest a denial, even though paid under waiver, the beneficiary is on notice that similar services will be denied in the future. When an agency retains waiver of liability, it is in a much better position to continue providing services in the "grey" areas without fear of not being reimbursed.

Let me give you an example of the type of case that is being brought to our attention. An 86 year old woman living in a southern state suffered from Alzheimer's disease, leg contractures, a series of mild strokes, anemia, anorexia, bronchitis, skin ulcers, acute urinary tract infection, and urinary and bowel incontinence. She was an extremely weak, confused, totally dependent patient who lived alone. Her two children took turns coming by to be with her. Her condition deteriorated, and she had to be readmitted to the hospital. What this elderly Alzheimer's victim got from

Medicare was denial of all her home health care on the claim that skilled nursing care was no longer needed—and this notice from HCFA which says in part:

> "...The Services you received do not meet the Medicare qualifications for payment...payment will be made under waiver of liability...subsequent to that date, no further payment can be made...should you again receive services for the same type care, you will be responsible for all charges..."

Beneficiaries as old, sick, and debilitated as this woman are not in a position to mount an effective appeal against a massive Federal bureaucracy. Intermediaries are fairly safe in making denials on the most seriously ill and vulnerable patients, since there is not much chance of the beneficiary fighting back aggressively, especially without representation by the HHA nurse who knows the patient and system best. We believe that HCFA's prohibition was precipitated by the very success of providers representing beneficiaries in the appeals process. Those with the most knowledge of the case and the process are banned because they have demonstrated their effectiveness.

The refusal to allow home health personnel to represent the beneficiary coincides with a significant upsurge in denials. The Congressional mandate to reduce the number of fiscal intermediaries processing claims for free standing home health agencies to no more than 10 has led to a competition among the existing intermediaries to be included in the final configuration. FIs have tried to demonstrate their mettle by increasing denials; even many of those not tentatively selected in HCFA's proposed regulations of April 10, 1985, have come under intense HCFA pressure. In some states, this has resulted in confusion, wholesale denials, and numerous HHAs with exemplary records losing waiver of liability. This FI competition also coincides with HCFA's requirement that intermediaries recover $5 for every $1 received for medical review. The pressure on FIs to make denials—any denials—is intense.

In responding on July 3, 1985, to an inquiry of the House Select Committee on Aging, Lawrence DeNardis, the Acting Secretary for Legislation of the Department of Health and Human Services, stated:

> "The cost/benefit ration of 5:1 for medical review by intermediaries is based on historical data. Both medical review and audit are critical elements. Failure to succeed in these elements could lead to various contract actions including termination."

There is of course no explanation of this "historical data." We suggest that there is no such basis and that the 5-1 ratio is an arbitrary tool, pure and simple, to cut costs. An FI which values its contract with HCFA will do what it has to to pass.

In his July 3 response to the House Aging Committee, Mr. DeNardis also stated:

> "Data on claims reversals are factored into the intermediary performance evaluation program through a series of elements which measure the accuracy of the intermediary reconsideration determinations and the accuracy of the medical review determinations."

We are somewhat confounded by this since we have been informed by other sources within HCFA and indirectly by FIs that this is simply not the case; FIs are not held accountable for their errors in coverage determinations. I would urge your Committee to take a look at this issue for we believe it has profound implications for patient access to services.

We believe HCFA's plan is to encourage denials, with the knowledge only a percentage will be contested. If FIs are not held accountable for their own errors, as more HHAs experience arbitrary denials and become familiar with the appeals process, the bottom line will reflect phantom savings, consumed in part by the cost of appeals and adjudication. And the cost in human terms is beyond calculation. Some beneficiaries will go without care and others will be subjected to needless institutionalization.

HCFA has acknowledged that its FIs overturn their own denials 32.4 percent of the time upon reconsideration. Although we do not have the breakdown by type of provider, between October 1, 1984, and February 28, 1985, Administrative Law Judges decided 840 cases involving Part A Medicare denials. Denials were reversed in 57.6 percent of these cases. In my own Region IV, HCFA Ombudsman Angelique Pullen stated in a letter to AFHHA's Executive Director, dated April 23, 1985: "A review of all HHA hearings revealed that 90% of the level of care denials had been overturned by the Administrative Law Judges."

Is it any wonder that HCFA wants to discourage appeals?

The upsurge in denials in my own agency began with my FI entering the competition for selection as one of the ten regional intermediaries. The denials I have received are arbitrary and must be contested. Yet I have seen my own patients intimidated in what clearly is an attempt to prevent them from exercising their right to appeal. The Atlanta Regional Office has sent a form, which I wish to submit for the record, to a number of beneficiaries who have appealed denials. A form of this type coming from the Department of Health and Human Services carries the implication that something is amiss. Beneficiaries are caught up in a bewildering process and are fearful that they will lose their Medicare benefits and Social Security payments if they answer "incorrectly." Thirty-eight of my patients have taken their denials to the Administrative Law Judge level and many have received this form. Furthermore, beneifciaries have been contacted personally by the Office of Hearings and Appeals in Atlanta and led to believe that they must appear in person to pursue their appeals, when there is no such requirement. In one case, a beneficiary was visited by a woman who stated she was from the Social Security Office and advised to sign a form requesting that her Medicare hearing be dismissed. She was afraid that her Social

Security checks would be terminated if she did not comply.

We urge you to keep Administrative Law Judge hearings within the Office of Hearings and Appeals of the Department of Health and Human Services, rather than move the function to a separate office within HCFA, as has been suggested. We believe that ALJs would lose their current independence if HCFA gained control of the process. We would see pressure to uphold denials, akin to the pressure exerted on judges ruling on Social Security disability cases several years ago.

There are several options, if Congress feels that there is a problem:

- o develop a cadre of judges within the present Office of Hearings and Appeals and allow them to specialize in Medicare cases, or
- o provide present ALJs with more training to enable them to become more proficient in the details of the Medicare program.

However we are just not convinced that there is a problem in this area. Judges throughout the United States routinely handle a variety of cases, from divorce to murder to civil suits. They are not expected to be experts in each of these areas, but to be able to research the law and precedents as cases arise.

We urge prompt enactment of S.1551 and an exploration of the intertwining issues of denial quotas and fiscal intermediary performance. Such action would help focus the Medicare program back on provision of quality health care to elderly and disabled Americans, the purpose for which it was instituted.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Region IV
101 Marietta Tower
Atlanta GA 30323

June 1, 1985

Mr.

Laurel, MS

We would appreciate your looking at the enclosed copy of the Request for Hearing and answering the following questions:

1. Did you sign the enclosed request form?
   ___ YES ___ NO
2. If Yes, did you understand what you were signing?
   ___ YES ___ NO
3. Did someone from Home HEALTH AGENCY MULTI COUNTY ask you to sign it?
   ___ YES ___ NO

   If so, what were you told?

4. Do you still want the Hearing?
   ___ YES ___ NO

Your Signature

Date

PLEASE SIGN, DATE AND RETURN THIS TO US IN THE ENCLOSED ENVELOPE.

Summary of Section 228 --

ADVANCE APPROVAL OF SKILLED NURSING FACILITY AND HOME HEALTH BENEFITS:

The Secretary is authorized to establish, by diagnosis, minimum periods during which the posthospital patient would be presumed to be eligible for skilled nursing facility and home health benefits.

Effective date: January 1973

ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE

Sec. 228. (a) Section 1814 of the Social Security Act (as amended by section 227(b)(2) of this Act) is amended by adding at the end thereof the following new subsections:

"Payment for Posthospital Extended Care Services

"(h)(1) An individual shall be presumed to require the care specified in subsection (a)(2)(C) of this section for purposes of making payment to an extended care facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—

"(A) the certification referred to in subsection (a)(2)(C) of this section is submitted prior to or at the time of admission of such individual to such extended care facility,

"(B) such certification states that the medical condition of the individual is a condition designated in regulations,

"(C) such certification is accompanied by a plan of treatment for providing such services, and

"(D) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited periods of time with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

"(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A), (B), or (C) of paragraph (1).

"Payment for Posthospital Home Health Services

"(i)(1) An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for posthospital home health services furnished by such agency to such individual if—

"(A) the certification and plan referred to in subsection (a)(2)(D) of this section are submitted in timely fashion prior to the first visit by such agency,

"(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

"(C) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

"(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1)."

(b) The amendment made by subsection (a) and any regulations adopted pursuant to such amendment shall apply with respect to plans of care initiated on or after January 1, 1973, and with respect to admission to skilled nursing facilities and home health plans initiated on or after such date.

Legislative history (228)

Sen. Rept (92-1230)
pp. 198-200

H. Rept (92-231) pp. 97-98

Advance Approval of Extended Care and Home Health Coverage Under Medicare

(Sec. 228 of the bill)

Under present law, extended care benefits are payable only on behalf of patients who, following a hospital stay of at least 3 consecutive days, require skilled nursing care on a continuing basis for further treatment of the condition which required hospitalization. The posthospital home health benefit is payable on behalf of patients who, following hospitalization or an extended care facility stay, continue to require essentially the same type of nursing care on an intermittent basis, or physical or speech therapy. However, extended care facilities and home health agencies often care for patients who need less skilled and less medically oriented services in addition to patients requiring the level of care which is covered by the program.

Under current law, a determination of whether a patient requires the level of care that is necessary to qualify for posthospital extended care or home health benefits cannot generally be made until some time after the services have been furnished. The committee is aware that in many cases such benefits are being denied retroactively and that another provision in the committee bill, which would revise the definition of extended care to permit coverage of additional types of skilled care, would not eliminate the probability that such retroactive denials will continue. The harsh result is that the patient is faced with a large bill he expected would be paid or the facility or agency is faced with a patient who may not be able to pay his bill. The uncertainty about eligibility for these benefits that exists until after the care has been given tends to encourage physicians to either delay discharge from the hospital, where coverage may less likely be questioned, or to recommend a less desirable, though financially predictable, course of treatment. The aggregate effect is to reduce the value of the posthospital extended care and home health benefits as a continuation of hospital care in a less intensive—and less expensive—setting as soon as it is medically feasible for the patient to be moved.

The committee believes that to the extent that valid criteria can be established posthospital extended care and home health benefits should be more positively identified by type of medical condition which ordinarily requires such care and that minimum coverage periods should be assured for such conditions. To achieve this purpose the committee has concurred with a provision in the House bill which would authorize the Secretary to establish, by medical conditions and length of stay or number of visits, periods for which a patient would be presumed to be eligible for benefits. The Secretary would undertake such activities to the extent that a Professional Standards Review Organization was not exercising comparable responsibility in an area. These periods of presumed coverage would be limited to those conditions which program experience indicates are most appropriate for the extended care or home health level of services following hospitalization, taking into account such factors as length of hospital stay, degree of incapacity, medical history and other health factors affecting the type of services to be provided.

The committee recognizes that, in order to avoid the risk of presuming coverage (by general medical category) in substantial numbers of cases where extended care or home health care may not be required, presumed coverage periods must necessarily be limited in duration and will not, in many cases, encompass the entire period for which the patient will require covered care. Nevertheless, these minimum presumed periods will provide a dual advantage over the present system of coverage determination by (1) encouraging prompt transfer through assurance that the admission or start of care will be reimbursed and (2) identifying in advance the point at which further assessment should be made, on an individual case basis, of continuing need for extended or home health care. Where request for coverage beyond the initial presumed period, accompanied by appropriate supporting evidence, is submitted for timely advance consideration, it is expected that a decision to terminate extended care or home health coverage would ordinarily be effected on a prospective basis. For those conditions for which specific presumed periods cannot be established, current procedures for determining coverage would continue to apply. However, the Professional Standards Review Organization, which would be established under section 249F of the committee's bill (or the fiscal intermediary where no PSRO is performing such functions) should be able to make appropriate reviews on a timely basis for such admissions.

To prevent abuse of the advance approval procedure the PSRO or intermediary (in the absence of a PSRO) and facilities would be expected to monitor, through periodic review of a sample of paid stays, utilization review committee studies, and similar measures, the reliability of individual physicians in describing the patients' conditions or certifying patients' needs for posthospital extended care and home health services. The Secretary could suspend the applicability of the advance approval procedure for patients certified by physicians who are found to be unreliable in this respect.

This provision would be effective January 1, 1972.

Senator **Durenberger**. I thank all of the witnesses for their ability to summarize a difficult issue. Some of you in your full statements get into the issue of the role of the provider in the appeals process, and in light of the testimony from HCFA earlier today you might like to elaborate more for the record on that particular issue of the relationship between providers and beneficiaries in this process. And Ms. Steele took advantage of her time to hit at that issue some more. I think it would be helpful for the record to pick up on that part of Henry's testimony and, assuming there is an alternative view to that or at least a different view, to elaborate on your testimony in that regard.

I want to just take a minute and ask two hospital representatives about the necessity for an appeals process from PRO determinations.

I assume, first, as opposed to some of these other appeals where you see a benefit to the beneficiary, that here the problem is either that the beneficiary never gets admitted to a hospital or they get admitted and get sent out before the hospital might think they ought to be sent out. But the beneficiary is at home already. So, I'm not sure how much good that is.

It strikes me that the reason the hospitals would like to see an appeals process on PRO determinations that would largely benefit the hospitals. My question becomes: To whom would you appeal the kinds of decisions that PRO's take, since we have constructed them to do medical necessity, and appropriateness of setting, and quality review, and reasonableness, and we have literally a peer involvement in the process? To whom would you take that appeal, if you expanded this process beyond the reconsideration that is already in there?

Mr. Cox. I think, first of all, Mr. Chairman, you could begin by taking it to administrative law judges. And then, if there was a need for an appeal beyond that process, it can go to Federal court.

I think the real problem in this area is the concern that the ALJ's and the Federal courts would be overburdened by the volume of appeals that would be generated.

Senator **Durenberger**. Well, my concern is they are not qualified to make some of these kinds of judgments.

Mr. Cox. They make very difficult judgments in a host of other areas that are very technical and difficult to make judgments on.

Senator **Durenberger**. Oh, I know they do that.

Jack?

Mr. **Owen**. I would make a comment, Mr. Chairman. It seems to me that this might be a logical role for the Super-PRO that is supposed to be looking at what is happening in these PRO's. I think what Bill has suggested I certainly would support, but the problem is the timing and the length of time of going through the administrative process. It seems to me that there ought to be some faster way to get some kind of a preliminary appeal.

I am not so sure that the problem is so much one of the hospitals as it is the appealing itself—the beneficiary has no way to appeal from the PRO. What I hear coming out of the Senate Aging Committee, for instance, is that the beneficiaries are left with nobody to represent them, and there is no way to appeal. As you said, they are back home, or they don't understand that they have an appeals process. And that, I think, is probably equally as important as it is for the hospital to have the possibility of appealing. But the hospital, too, should have that appeal.

I don't understand why people are opposing appeals. Appeals don't necessarily mean you are going to win; they just mean you have a right to fairness. And to me, that is what the American system is all about.

Senator Dureoberger. Yes. I don't want to be perceived as unsympathetic, because you can get a hospital and a doctor to gang up on patients, blame the DRG system, and have them all standing out on their ear in some States and some environments. I don't think that could go on very long. And I don't think an appeals process cures it. The appeals process is supposed to hit at those selective situations where, in a particular situation, a person is being discriminated against in one way or another, rather than a PRO which demonstrates continued insensitivity time after time. That is another kind of a problem.

So, I just want to say you know my involvement with the PRO process. I am sensitive to the fact that we need something there to help people. I am not sure that the usual appeal process is the right one. If somebody can come up with something else, I think we ought to take a look at it.

Mr. Cox. I think we can all come up with some fairly good ideas as a point from which to start, in terms of the discussion of this issue.

Senator Durenberger. All right.

Mr. Cox. I know Jack and our association would be more than happy to work with the committee staff to look into the prospects of developing an adequate mechanism.

Mr. Owen. I would second that.

Senator Durenberger. All right, very good. Thank you all for your testimony; we appreciate your being here.

Now we are ready for our next panel, which consists of John Pickering, the chairman of the American Bar Association Commission on Legal Problems of the Elderly; Dr. Martin Merson, a member of the American Association of Retired Persons from Sun City, AZ; Arlene Lapp from Portland, OR, who is accompanied by Bruce Fried, the staff attorney for the National Senior Citizens Law Center in Washington; and Leonard Lesser, special counsel for the National Council of Senior Citizens.

Ladies and gentlemen, we welcome you and your associates here today. Your full statements will be made part of the record. You may proceed to summarize them within the 5 minute time limit. Feel free to assume that we have read all of your statements, which I have and I trust others will, so that you don't have to get them all in when the red light hits you. But we deeply appreciate your taking the time and the inconvenience to represent thousands of other citizens who can't be here today to testify on this very important issue.

We will begin with John Pickering.

STATEMENT OF JOHN PICKERING, CHAIRMAN, AMERICAN BAR ASSOCIATION, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, AND PARTNER, WILMER, CUTLER & PICKERING, WASHINGTON, DC; ACCOMPANIED BY NANCY COLEMAN, STAFF DIRECTOR OF THE COMMISSION

Mr. PICKERING. Thank you, Mr. Chairman.

I appear on behalf of the American Bar Association and am the current chairman of the association's commission on the legal problems of the elderly. Appearing with me is our staff director, Nancy Coleman.

Both the association and the commission are deeply concerned that all persons, and particularly our elderly citizens, be given procedural due process. We are accordingly pleased to support the bill before this committee introduced by yourself, S. 1551, the Fair Medicare Appeals Act of 1985. This bill would remedy deficiencies in the current review procedures for claims under part B, the medical insurance part, of the Medicare Program. It would accord due process by giving part B claimants the same fair and just review treatment currently provided for claimants under part A, the hospital and institutional payment part of Medicare.

Current review procedures for part B claims are deficient in several respects. Those are covered in detail in my prepared statement; they have been commented on by previous witnesses, and I will not take the committee's time to discuss them further.

S. 1551 would remedy these deficiencies by treating part B claims substantially like part A claims, for purposes both of administrative hearing before an ALJ, which is not given now, and for the purpose of judicial review.

The amounts involved would require $500 or more for an ALJ hearing and $1,000 for judicial review. The bill provides for aggregation of claims to determine the amount in controversy by the Secretary, pursuant to regulations. And we believe that these levels are sufficient to avoid any undue workload coming into the system as a result of the changes this bill would make.

Now, we also realize, Mr. Chairman, that the part B review process has been found to satisfy minimal due process requirements, at least in the absence of a more particularized showing in a specific case.

But, Mr. Chairman, our elderly citizens are entitled to more than minimal protection. You have heard the testimony this morning of some of the problems that have arisen. Our elderly citizens should have the same due process rights that part A claimants, including institutions, enjoy.

There is no longer any principled basis for treating part B claimants differently than part A claimants, and denying them administrative and judicial review, no matter how egregiously or arbitrarily their claims are treated. And this is particularly true given the shift in emphasis now to outpatient care rather than inpatient, institutional care.

We, accordingly, urge the bill's adoption as a matter of simple justice for our older Americans, and the American Bar Association thanks the committee very much for this opportunity to appear in support of this needed legislation.

Senator **Durenberger**. John, we thank you for taking the time to be here, as well.

Dr. Merson, we welcome you, and your statement will be made part of the record.

[Mr. Pickering's written testimony follows:]

AMERICAN BAR ASSOCIATION

STATEMENT

OF

JOHN H. PICKERING

ON BEHALF OF

THE

AMERICAN BAR ASSOCIATION

CONCERNING

MEDICARE DUE PROCESS APPEALS
S. 1551

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

WASHINGTON, D.C.

NOVEMBER 1, 1985

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to testify today on behalf of the American Bar Association, (ABA) the world's largest voluntary professional association. I am also pleased to appear on the side of fairness, efficiency, common sense and sound legal principles on a subject of grave importance and concern, particularly to the disabled, the poor and the elderly. I am currently the chairperson of the ABA Commission on Legal Problems of the Elderly. The Commission as well as the Health Care Law Committee of the ABA Young Lawyers Division have been concerned for many years with the way in which beneficiaries have been treated in the Medicare process. In 1980 these two entities took a resolution concerning fairness for Medicare Beneficiaries to the ABA House of Delegates which was unanimously adopted. The position of the American Bar Association is to ensure meaningful and efficient administrative and judicial review of Medicare reimbursement controversies under Parts A and B of the Medicare program. Legislation is needed to alleviate the lack of an adequate hearing process.

The ABA is in support of S.1551 which Senators Durenberger, Heinz and Chafee introduced earlier this year. The "Fair Medicare Appeals Act of 1985" would redress many of the problems which beneficiaries currently have in obtaining review of claims which are denied. Access to hearings and judicial review with respect to determinations under section 1869(a) of the Social Security Act is only an extension of what was initially considered in the original Medicare Act.

Currently Medicare law and regulations have led in many cases to meaningless, time-consuming, and expensive administrative review of Medicare reimbursement controversies that cannot be resolved at the administrative level. Judicial interpretations of the statute have often closed the doors to meaningful judicial review of challenges by participants in the Medicare program to regulations and other policies of the Department of Health and Human Services (HHS), even after all available administrative appeals have been exhausted. Numerous controversies which can be resolved only by the courts have, in many jurisdictions, become hopelessly entangled in battles over the existence of subject matter jurisdiction. Consequently, claimants under Parts A and B have been forced to engage in forum shopping in an attempt to find a court that will decide the merits of their claims in a timely fashion; the resolution of Medicare reimbursement controversies on their merits has generally become a secondary consideration.

The appeals process for claims disputes under Medicare Part B is inequitable and often leaves Medicare beneficiaries and physicians who accept assignments with no adequate remedy for injuries resulting from arbitrary and invalid actions by HHS.

The only review of adverse determinations by carriers regarding Part B claims that is prescribed under the Medicare Act is the so-called "fair hearing" required to be offered by carriers with respect to controversies involving amounts in dispute of $100 or more. 42 U.S.C. §1395u(b)(3)(C). As a practical matter, under the current procedure there can be no truly "fair" hearing since the hearing office is engaged by the carrier who rendered the initial adverse determination. Under these circumstances, it is unreasonable to expect the hearing office to be impartial.

The discretion of hearing officers also is limited by regulation. Hearing officers are required to comply with regulations, policy statements, instructions, and other guidelines issued by the Health Care Financing Administration. 42 C.F.R. §405.860.

There are other inequities resulting from current review procedures. Ceilings are established through letters to carriers rather than through rulemaking. Carriers are instructed by HHS to implement ceilings even though the Medicare law requires carriers, rather than HHS, to make reasonable charge determinations under Part B. The only available right of appeal of a carrier's applications of HHS's ceiling under the statute is to a hearing officer appointed by the carrier. However, hearing officers are bound by regulation to comply with policy statements, instructions, and other guidelines of HHS and its components. Thus, hearing officers, like the carriers who engaged them, must adhere to HHS's ceiling regardless of whether charges higher than the ceiling amount are reasonable within the meaning of the law.

The inability of hearing officers to hear challenges to actions of HHS has generally left Part B claimants with no forum to challenge arbitrary and invalid administrative

policies. The law does not provide for administrative review of Part B claims. As indicated above, "fair hearings" under Part B are conducted by individuals engaged by carriers; there is no administrative tribunal comparable to the Provider Reimbursement Review Board in Part A to which a Part B controversy may be appealed. Moreover, the law has been interpreted consistently by the courts to preclude judicial review of Part B claims. See, e.g., *Schweiker v. McClure*, *Drennan v. Harris*, CCH Medicare and Medicaid Guide Para. 30,060, Civ. No. 76-2766 (9th Cir. Sept. 4, 1979); *Pushkin v. Califano*, 600 F.2d 486 (5th Cir. 1979); *Cervoni v. Secretary of HEW*, 581 F.2d 1,010 (1st Cir. 1978); *Pritt v. Nationwide Insur. Co.*, 548 R.2d 1,129 (4th Cir. 1977); *Greenspan v. Blue Cross/Blue Shield of Greater New York*, 432 F. Supp. 1,339 (E.D.N.Y. 1977); *Simoncelli v. Weinberger*, 418 F. Supp. 87 (E.D. Pa. 1976); *Kuenstler v. Occidental Life Insur. Co.*, 292 F. Supp. 532 (C.D. Cal. 1968). But see *Waitley v. Califano*, CCH Medicare and Medicaid Guide Para. 29, 141, Civ. No. 77-2147 (D. Kan. 1978). Cf. *St. Louis University v. Blue Cross Hospital Serv.*, 537 F.2d 283 (8th Cir.), cert. denied, 429 U.S. 977 (1976).

The legislative history of the Medicare Act indicates that judicial review of Part B "claims" was not intended by Congress because it was felt that claims under Part B "will probably be for substantially smaller amounts than under Part A." S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 54-55, 1 *U.S. Code Cong. & Admin. News* 1,995 (1965). The assumption reflected by that statement has been shown to be erroneous in many circumstances. Individual claims of Medicare beneficiaries and physicians for reasonable charge reimbursement under Part B are generally less than institutional provider claims for cost reimbursement under Part A because provider claims generally involve costs of services rendered to many Medicare beneficiaries over a period of time. However, aggregate claims of physicians and Medicare beneficiaries under Part B arising from a single invalid action of HHS affecting a single service covered under Part B may be or involve substantial sums of money.

The problem is further aggravated by the decisions of several courts which have interpreted the statutory provision precluding judicial review of Part B "claims" (i.e., 42 U.S.C. §405(h)) also to preclude subject matter jurisdiction over matters not involving disputes as to claims for benefits but possibly having an indirect bearing, albeit remote, upon the amount of benefits allowed.

The dilemma confronting claimants under Part B is illustrated by the Fifth Circuit's decision in Pushkin v. Califano, 600 F.2d 486 (5th Cir. 1979). In Pushkin several licensed optometrists brought an action challenging the constitutionality of a provision of the Medicare law defining reimbursable services under Part B and the validity of a regulation promulgated thereunder, and seeking declaratory and injunctive relief. Even though the suit did not involve a claim for benefits, the court determined that the challenge to the regulations could be recast to a claim for benefits and that the resolution of the constitutional challenge would determine whether or not benefits were to be awarded. Thus, the court held that it was precluded by 42 U.S.C. §405(h) from taking subject matter jurisdiction over the case.

The Fifth Circuit recognized that the total preclusion of judicial review of the plaintiffs' statutory and constitutional claims would be constitutionally suspect, but, finding that the Court of Claims (unlike the federal district courts) was not precluded by 42 U.S.C. §405(h) from hearing such claims, concluded that judicial review was not totally precluded by its dismissal of the action. The problem, however, as recognized by the Fifth Circuit in its opinion, is that the Court of Claims is authorized only to grant monetary damages and could not grant the declaratory and injunctive relief sought by the plaintiffs. Thus, the Fifth Circuit's decision in effect closed the doors to the only effective relief for the plaintiffs, i.e., an injunction against the enforcement of allegedly invalid regulations.

Decisions such as these, coupled with the regulatory limitations upon carrier-appointed hearing officers, result in Medicare beneficiaries being conclusively bound by actions of HHS, no matter how arbitrary and illegal those actions may be.

S. 1551 would allow for the aggregation of claims which involve the delivery of similar or related services to the same individual or the aggregation of common issues of law and fact issuing from services furnished from to two or more individuals. This provision would greatly enhance the ability of beneficiaries to raise questions about coverage of benefits through a hearing process.

Judicial review is also provided for in S. 1551. It is clear that Congress intended that Part B claimants be entitled to a "fair" hearing of their claims. Congress intended that such a hearing be provided through procedures established by carriers, but HHS's regulations have thwarted this objective in certain cases. Certainly, Congress did not intend that Part B claimants be denied access to any forum where a fair resolution of their claims could be obtained.

The American Bar Association strongly urges the Health Subcommittee to approve S. 1551 and to advocate vigorously for its adoption by the full committee. It is clearly an issue of fairness which greatly benefits America's elderly.

STATEMENT OF MARTIN MERSON, PH.D., MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS, SUN CITY, AZ

Dr. MERSON. Thank you, Mr. Chairman. I am delighted to be here this morning to share with this committee my frustrating experience in appealing a Medicare part B claim, and to be representing the American Association of Retired Persons on this very important policy issue.

You have before you a lengthy written statement, which I respectfully request be made part of the committee record. I will briefly recount my experience with the part B appeals process in my presentation this morning.

My story and the stories of my fellow witnesses are about the basic fairness, or should I say lack of fairness, in the system that decides the limit of Medicare part B coverage eligibility and payment.

Our stories illustrate what happens when policy discretion resides solely in one place, and no mechanism exists to balance legitimate competing interests. The predictable result is unchecked authority and arbitrary decisions affecting basic rights under Medicare.

The surgery that was the subject of my appeal was performed on May 16, 1983. But to understand what happened in 1983, you have to go back to 1942, while I served as executive officer of the Advanced Naval Base at Guadalcanal on the British Solomon Islands.

While serving there, I contracted a deadly viral disease known as "Japanese-B encephalitis." I had 1,000 men and 100 officers under my command. Most of my men who incurred this disease died; I was one of the few survivors. But the disease has taken its toll. It severely damaged the extrapyramidal nerves, which has left me with a severe tremor of the parkinsonian variety. The tremor has grown worse over the years and has particularly affected the right side of my body, including the right eye, where the glaucoma pressure is far more severe and threatening than the glaucoma in my left eye.

By February 1982 I had developed, in addition to glaucoma, severe cataracts in both eyes. In order to have any vision at all, it was decided that the cataract in my right eye should be removed. The surgery was performed at the eye center at the National Naval Medical Center in Bethesda. The surgeon, unfortunately, did not implant a lens at that time, because he believed that the glaucoma brightsia, if it could not be controlled by drugs, would have to be gotten at surgically, and that an implanted lens would be an impediment. As a result, I ended up with no sight in my right eye for a period of about 13 weeks, at which time they fitted me for a soft lens.

I am one of a large percentage of patients who could not tolerate the soft lens. I got a succession of corneal ulcers.

Therefore, the soft lens had to be left out entirely. When your cataract is removed, you lose your natural lens; so you have no vision.

Now, this operation was performed, as I have said, at the National Naval Medical Center. At that point I was completely frustrated and went back to the eye surgeon, who suggested that the outstanding man in the country was Dr. A.E. Maumenee of Johns Hopkins, the Wilmer Institute.

By a referral from the Navy, I went to Johns Hopkins. The doctor there was not able to touch the right eye because of the still-existent corneal ulcer. However, he was able to go in, extract the cataract in the left eye, and implant a lens which at least gave me vision in one eye. It was a great success.

I spoke to him almost immediately about correcting the situation in the right eye, which of course had left me without vision, and he was very reluctant to do that, simply because—if you bear in mind, I was retired from the Navy with "brain damage"—I was 77 years of age at that time, and he said it was too risky. I said, "Dr. Maumenee, I've got a couple of books I want to write, and I'm going to get them written, providing I can get some changes in this situation, because I am one of these part B people who may need a great deal of help in the future."

Let me say at this point, in listening to Mr. Desmarais' testimony, I do not recognize the part B that I was up against from that testimony. [Laughter]

I went into this appeals process believing that it would be fair and that I would get a fair shake. I have received no booklets. The only time I have learned that this fair-hearing procedure was final was about 30 days after I received the decision denying the claim in full. We went over to the Aetna office which handles the Medicare for Arizona, where I was then living, and I read the appeals process in a booklet. That was the very first time.

I am a reasonably well-educated Medicare recipient. I am a graduate of the Naval Academy, I am a graduate of Harvard Law School, I have a Ph.D. in political science from Heron Ballistia, NC. I would say that 99 percent of Medicare recipients facing a part B problem haven't the faintest idea what it is all about, and they are not going to get any help from the carrier, they are not going to get any help from the fair hearing offices. I don't know where they get those people, but to say they are inadequate is the understatement of the year.

Let me say one other thing: We are all very conscious of this huge deficit which confronts us today. I am not at all sure that if you give people in my position a fair appeals process, as recommended by AARP, it is going to add to costs. As a matter of fact, this hearing lasted 1½ hours. There was a professional stenotypist there. I don't know how much they charge, but it could have been done with a simple little reporting mechanism. I don't know what the fair hearing officer receives in the way of payment, but surely we can make this system much more efficient and give some due process at the same time.

I am delighted to hear the opinion of the American Bar Association. It is vitally needed.

Thank you.

Senator DURENBERGER. Thank you very much, Doctor.

Arlene Lapp.

[Dr. Merson's written testimony follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

before the

SENATE FINANCE COMMITTEE
Subcommittee on Health

on

MEDICARE APPEALS

November 1, 1985

Presented by:
Dr. Martin Merson

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

SUMMARY STATEMENT
on
Medicare Appeals
November 1, 1985

1. Medicare beneficiaries are facing a health care system in flux. The reliability of the Medicare benefit is now in question. The out-of-pocket costs for services continues to escalate for Medicare beneficiaries, despite large savings for the federal government. Beneficiaries are facing a system that is being ratcheted down with little or no regard for the consequences to their health care needs. It is within this context that the reform of basic Medicare program policies and procedures must be viewed.

2. Rights at issue when questioning a Medicare determination are so important that they require the greatest level of procedural safeguards and review.

3. The Part B appeals process illustrates what happens when policy discretion resides solely in one place and no mechanism exists to balance legitimate competing interests. The predictable result is unchecked authority and arbitrary decisions affecting basic rights under Medicare.

4. The incentives to discharge patients earlier under the DRG prospective payment system, combined with a PRO review function that is not committed to quality of care, focuses increasing attention on the process by which a beneficiary contests a discharge decision.

5. There is controversy surrounding the manner in which the hospitals have implemented the notice process.

6. The appeals process often requires that patients place themselves at financial risk in order to obtain prompt PRO review of a non-coverage decision.

7. Medicare should be covered by the Administrative Procedures Act (APA).

8. Medicare must establish a formal system for reporting administrative decisions short of judicial review.

9. HHS should establish more stringent claims processing standards to prevent underpayment of beneficiary claims.

10. HHS should consider how well carriers and intermediaries review and resolve discrepancies in claims and how often their decisions are reversed on appeal as part of the carriers and intermediaries' evaluation of performance for continuing their contract with the Medicare program.

11. Disputes regarding determination of entitlement to benefits and the amount of benefits under Part B should be heard by an Administrative Law Judge (ALJ). Where the amount in controversy is $1,000 or more, then the decision of the ALJ should be subject to judicial review.

12. PRO review of physician-initiated discharges is within the scope of PRO review, which authorizes PROs to "review some or all of the professional activities ... for the purpose of determining whether such services are or were reasonable and medically necessary and whether such services and items are not allowable" under Medicare.

13. The patient or his representative should receive notice of appeal rights at time of admission and that notice should be renewed when the patient is advised of possible discharge.

14. The "notice of noncoverage" issued to the patient by the hospital should inform the patient when the physician opposes the discharge that will ensue.

15. At the very minimum, the patient should receive a PRO review of a continued stay denial within 48 hours of making the request.

16. The kind of hearing provided to the beneficiary before discharge should be given further consideration. The current regulations require a purely paper hearing, with no opportunity for oral presentation.

17. Further consideration should also be given to whether the PRO can be an impartial decision-maker.

CONCLUSION

The Medicare program is experiencing much needed change. In the enthusiasm for controlling spending, however, we cannot ignore the real world consequences of the incentives that have been unleashed. The recommendations outlined in this testimony provide an essential mechanism to assure beneficiaries and providers that the quest for cost containment will not be at the expense of the quality of care afforded Medicare patients or at the perversion of notions of basic fairness in handling Medicare claims.

INTRODUCTION

Thank you, Mr. Chairman. My name is Martin Merson. I am proud to be here today representing the American Association of Retired Persons. I thank you on behalf of myself and the twenty million members of the AARP for this opportunity to petition our government for redress of the serious grievances we have concerning the administration of the Medicare program. The story you will hear from me, and the stories you will here from my fellow witnesses today describe a great deal more than just a few who fell through the cracks of Medicare.

Our stories describe the process by which rights under Medicare are decided. Our stories are about the basic fairness of the system that decides the limits of Medicare coverage, eligibility, and payment. To a very great extent, our stories define fundamental values in our society.

My testimony is about the frustration of pursuing an appeal of the amount Blue Cross/Blue Shield, the Medicare carrier in Maryland, determined to be the reasonable cost of a very delicate lens implant in my right eye. My story illustrates what happens when policy discretion resides solely in one place and no mechanism exists to balance legitimate competing interests. The predictable result is unchecked authority and arbitrary decisions affecting basic rights under Medicare.

But the rights at issue when questioning a Medicare determination are so important that they require the greatest level of procedural safeguards and review. My testimony underscores the need for fundamental changes in Medicare procedures. It includes four main themes: (1) the context of the Medicare program today; (2) the recounting of my discouraging experience appealing an arbitrary decision on a Part

B claim, and; (3) new problems in the Part A appeals process; and (4) AARP's recommendations for strengthening Medicare procedures.

THE CONTEXT OF MEDICARE

The fall of 1985 finds the Medicare program reeling from a succession of major changes that have cut tens of billions of dollars from the program over the past four and one-half years. Runaway inflation in the health sector of the economy has been the most important factor driving up Medicare expenditures. Reacting to huge deficits in the federal budget and the seemingly uncontrollable increases in federal health spending, the Administration and Congress changed the basic incentives in the Medicare program.

The most important change has been the implementation of the Medicare prospective pricing system (PPS) based on diagnosis related groups (DRGs). Before PPS, hospitals were paid on a cost basis, the more services provided and the longer a patient stayed in the hospital, the more the hospital was paid. Under PPS, the incentives to the hospital are just the opposite -- to provide fewer services and get the patient out of the hospital as quickly as possible.

This new system has had a dramatic effect on the Medicare program. Admissions into the hospital are down. More procedures than ever before are being performed on an outpatient basis. The average length of a Medicare stay (ALOS) has dropped almost two days over the past two years. As a consequence of these changes, total patient days are down resulting in major savings to the Medicare program. There is a growing body of evidence, however, that the new Medicare incentives are forcing patients out of the hospital quicker and sicker than in the past and that the quality of care for Medicare beneficiaries is falling.

Moreover, PPS has shifted a substantial portion of the costs of health care services to beneficiaries. Quicker discharges and the growth in the number of outpatient services are but two of the factors igniting the huge increases in beneficiary liability under Part B. Beneficiaries' liabilities on unassigned claims for the differences between actual and allowed charges alone (the so-called charge reductions) was about $2.7 billion in FY 1984 -- up from only $0.9 billion in FY 1978.

It is sobering to realize that the average Medicare recipient paid the same percentage of income out-of-pocket for health care in 1984, (15 percent), as the average older person paid in 1966, the year Medicare began. It is alarming that older persons are projected to spend, on average, 19 percent of their income out-of-pocket for health care by 1990.

Medicare beenficiaries are facing a health care system in flux. The reliability of the Medicare benefit is now in question. The out-of-pocket costs for services continues to escalate for Medicare beneficiaries, despite large savings for the federal government. In short, Medicare beneficiaries are paying more for less care. They are facing a system that is being ratcheted down with apparently little or no regard for the consequences to their health care needs. It is within this context that the reform of basic Medicare program policies and procedures must be viewed.

MY EXPERIENCE APPEALING A PART B CLAIM

Although the surgery that is the subject of my claim was performed in May of 1983, you have to go back to 1942, to Guadalcanal in the

Solomon Islands to understand the special circumstances of my case. I was serving as Executive Officer of the advanced Naval base on Guadalcanal when I caught a deadly viral disease known as Japanese "B" encephalitis. Most men who incurred this illness died. I am one of the few survivors.

But the disease has taken its toll; it damaged my extrapyramidal system which has left me with a severe tremor of the parkinsonian variety. The tremor has grown worse over the years and has particularly affected the right side of my body. It has affected my right eye where the glaucoma is far more severe and threatening than the glaucoma in my left eye.

By February 1982, I had developed, in addition to glaucoma, severe, fast growing cataracts in both eyes. In order to have any vision at all, it was decided that the cataract in my right eye should be removed. The surgery was performed at the Eye Center at the Naval Medical Center in Bethesda. The surgeon did not implant a lens at that time, however, because he believed my glaucoma would have to be removed surgically and that an implant would be an impediment to that surgery. Thus, I ended up with no sight in my right eye and only marginal sight in my left eye due to the glaucoma and cataract.

In June, I finally was measured for and given a soft lens for my right eye at Bethesda Naval Hospital. The soft lens irritated my eye however, creating one corneal ulcer after another. It was removed leaving me again with no sight in my right eye and very little sight in my left eye.

The Navy surgeon who performed the operation told me that the most eminent man in the field was an opthalmologist at the Wilmer Institute at Johns Hopkins University Medical School. His name is

Dr. A. Edward Maumenee. He referred me to Dr. Maumenee who determined that my right eye was in no condition for further surgery. Thus, to give me any eyesight at all meant he had to work on the cataract in my left eye. In February 1983, Dr. Maumenee performed an intracapsular cataract extraction and lens implant on my left eye under a general anesthetic because I have no control over this severe tremor. Dr. Maumenee charged $2,000 for this procedure. Medicare approved $1,640 and paid $1,312. Private insurance covered most of the balance.

Dr. Maumenee's surgery on my left eye was a great success. You can imagine how anxious I was to have him try to restore vision to my right eye by performing a secondary lens implant. Dr. Maumenee was reluctant, however, to perform surgery on the right eye because my complicated medical history and age made such surgery risky. After months of consideration, Dr. Maumenee finally agreed to do the surgery, which was performed on May 16, 1983. Dr. Maunenee charged $1,800 for this procedure. Medicare approved $850 and paid $680. It is the large difference between what the carrier determined as reasonable and what the surgeon charged that was the focus of my appeal.

I went into the appeals process believing it to be fair, providing the kind of due process protections commensurate with the seriousness and importance of Medicare payment determinations. Sadly, I was very mistaken. Basic information about the process was not provided. For example, I did not learn that the hearing officer's decision was final until long after the hearing. A fair hearing procedure would require that an appellant understand the finality of what appeared to be just the first opportunity to present the reason for dissatisfaction with the carrier's determination. Lacking this important information, I went into the hearing without benefit of counsel.

The supposedly unbiased hearing officer, an employee of the carrier, acknowledged that the carrier did not consider the risks involved in my case or the difficulty of the fact situation confronting Dr. Maumenee. Though I gave a detailed recounting of my medical history and the consequent risks inherent in this surgery, the hearing officer disregarded my testimony and ruled against my claim. I have no avenue for redress under current law.

It is telling that he made several references during the hearing about relying on the carrier's medical staff to help him review the records. It stretches one's imagination to believe that such a practice results in objective and unbiased decisions. I believe the decision denying my claim was not fair and that the Part B appeals process is inherently unfair.

I have written to my Representative and to both of my Senators about the lack of due process and basic fairness in the Medicare Part B appeals process. I have written to the Secretary of the Department of Health and Human Services and many, many others trying to get the appropriate officials concerned about this issue. While some have been attentive to my plea, none have offered any hope of redress until, after months of frustration, I finally heard from the AARP that a broad coalition of interests were lobbying hard for changes in Medicare appeals.

The broad coalition of organizations supporting reform in the Part B appeals process is indicative of the scope of abuse occurring under the guise of thrifty administration. The Senate Finance Committee has a responsibility to Medicare beneficiaries and providers alike to require procedures that are commensurate to the Medicare rights at risk. The current system misses that criteria by a mile and must be changed.

Beneficiary problems with the Part B appeals process are well documented. New changes in Part A, however, concerning peer review organizations, portend new problems for beneficiaries appealing Part A decisions.

NEW PROBLEMS IN THE PART A APPEALS PROCESS

Continued Stay Denials Under Medicare Part A

The incentives to discharge patients earlier under the DRG prospective payment system, combined with a PRO review function that is not committed to quality of care, focuses increasing attention on the process by which a beneficiary contests a discharge decision. Most frequently this decision to discharge emanates from two sources: the hospital and/or the physician.

It would appear that if the attending physician makes the discharge decision, it is in the best interest of the patient. However, in many cases the informal pressures on physicians to discharge patients may be great. (See Report of the ASIM, October 1985.) Where hospitals post DRG statistics on the patients' charts, for example, it may not be necessary for the hospital to initiate a formal discharge: the physician will know that the hospital wants the patient discharged at or before the DRG amount is reached. An example of this is a practice in a California hospital chain of determining physicians' fees on a sliding scale based on how close their record of discharge is to the DRG reimbursements. The Medicare regulations, however, do not address whether a beneficiary may seek review of a physician-initiated discharge.

PROs have recognized that physicians respond to informal pressures to reduce admissions and shorten stays. The president of one PRO explained the effectiveness of informal pressures. "Just by knowing he has to justify every hospitalization, a doctor weighs marginal cases more carefully. And don't forget all those "agreements" by the doctors to shift a procedure outside the hospital or not to do it at all - we don't call those denials." Yet the appeals process does not apply when the physician initiates the discharge. In such case, no rights attach at all -- despite the fact that it is precisely in this situation that the patient may be most vulnerable, since he or she has received no notice that any appeal rights even exist, and is likely to rely on the physician's judgment.

The hospital may initiate a patient discharge by informally pressuring the physician to make the decision or by issuing a "notice of noncoverage". Hospitals can issue such notices pursuant to a January 3, 1984 final rule that allows hospitals to charge beneficiaries for items and services excluded from coverage on the basis of custodial care or medically unnecessary services if certain conditions are met and the services are furnished by the hospital.

When the hospital initiates the discharge -- with the agreement either of the physician or the PRO -- the hospital issues a "notice of noncoverage" to the beneficiary, informing him or her that it has been determined that an inpatient stay is no longer medically necessary, that the hospital will begin charging the patient if he or she remains in the facility after a two day grace period, and that the patient may request a formal PRO determination. If the patient remains in the hospital after two days, the PRO will make a formal decision which will be subject to reconsideration and appeal as an "initial denial determination".

The appeal rights for Medicare beneficiaries in PPS hospitals are thus closely tied to the review functions performed by the PROs. Before any appeal rights attach, the beneficiary must have received an "initial denial determination" from the PRO, defined as "(a) determination by a PRO that the health care services furnished or proposed to be furnished to a patient are not medically necessary, are not reasonable or are not at the appropriate level of care." According to the PRO Manual, such actions include "preadmission denials, admission denials, outlier days or costs denied, continued stay denials (e.g. as a result of hospital initiated notices), and services/procedures denied".

Appeals from denials of coverage are based on Section 1155 of the Social Security Act. This section provides that "(a)ny beneficiary who is entitled to benefits under (Medicare), and any practioner or provider, who is dissatisfied with a determination made by the (PRO) in conducting its review responsibilities" has the following rights: in every case, the right to have the PRO reconsider its determination; in cases involving $200 or more, the right to an administrative hearing and appeal; and in cases involving $2000 or more, the right to judicial review.

Despite the seemingly smooth process described above, there are many hurdles for the beneficiary, commencing at the point at which they receive the "notice of noncoverage".

In the first instance there is controversy surrounding the manner in which the hospitals have implemented the notice process. In proposed rules published on June 10, 1985 HCFA stated:

> "We have learned that many prospective payment hospitals have inappropriately implemented the notice process required by 412.42(c), resulting in a detrimental effect on beneficiaries and inappropriate program payments. Some examples of inappropriate practices have included the following:
>
> - Notices that do not contain all of the required elements.
>
> - Notices that do not make it clear that the hospital with the concurrence of the

attending physician or the PRO, has determined that the patient no longer requires hospital care. (The language of some notices has implied, in effect, that Medicare will no longer pay for the hospital stay or that Medicare benefits have been exhausted, or the language fails to fix responsibility for the decision on the hospital).

- Notices that give an incorrect date on which the beneficiary will become responsible for charges and sometimes make the beneficiary responsible retroactively to the date of admission. (In some cases, the notice is given after discharge).

- Some hospitals have not given specific notices but rather have required the beneficiary to sign a blanket statement upon admission accepting responsibility for whatever Medicare may not cover. The hospital then charges the beneficiary later if Medicare finds the stay or any part of the stay noncovered..."

Although the PROs have been instructed to monitor these notices, we are not convinced that all the problems have been remedied. Perhaps this increased scrutiny of the hospitals will only serve to increase pressure on the physicians to initiate the discharge, thereby avoiding the need for a notice to the patient.

Finally, the appeals process often requires that patients place themselves at financial risk in order to obtain prompt PRO review of a noncoverage decision. Under the explanation in the PRO Manual, it appears that while the patient receives only two grace days after the hospital's "notice of noncoverage", the PRO has at least three working days to respond to even an expedited review request (which must be requested by the beneficiary within three days). The instructions could be interpreted to allow the PRO to count those three working days from the day that the beneficiary's liability begins, since it is only if the patient remains in the hospital that the PRO has any obligation to conduct a prompt review. Even if the three working days begin when the appeal is received, review often will extend beyond the two grace days.

To make matters worse, if the attending physician agrees with the hospital's recommendation that the patient no longer needs inpatient care (thus, the hospital does not need to go to the PRO in order to send a notice of noncoverage) the patient must go to the PRO twice in order to obtain the final PRO decision. First, the patient must ask the PRO to review his or her case. If the PRO does not approve a continued stay, it will issue a "denial notice". If the patient still disagrees, he or she can request that the PRO reconsider its decision. The result of this reconsideration is the final PRO decision. Since it appears that the PRO has three working days to respond to each of these review requests, the patient's window of liability is substantially increased.

The current appeals process for continued stay denials is deficient. The timing and content of the notice raise many questions. The unavailability of appeal rights until the patient places himself at financial risk is causing the patient to leave rather than challenge a denial of benefits. If the patient is not willing or unable to risk his own funds, he will be discharged and there will be no expedited review. Thus, in too many instances Medicare benefits are terminated before the beneficiary receives a hearing. Moreover, the limited nature of the hearing (a paper review) and the risk that the PRO, which hears the appeal, will be biased against the patient, further serve to minimize the likelihood that the initial determination will be challenged.

AARP RECOMMENDATIONS FOR REFORMING MEDICARE PROCEDURES

The American Association of Retired Persons urges Congress to adopt the following recommendations to make Medicare procedures and decisions more accountable to beneficiaries and providers.

A. Recommendations for reforming general program procedures

1. Medicare should be covered by the Administrative Procedures Act (APA). Requiring Medicare to be covered under the APA will provide basic due process protections that currently do not exist under the program. First, APA jurisdiction over Medicare will require that the Secretary follow the procedures of notice of proposed rulemaking when issuing any regulation or rule with respect to Medicare. The public has a right to know and comment on the rules and regulations by which the government administers Medicare. Notice of proposed rulemaking is a basic due process protection that is long overdue in the Medicare program.

   Second, subjecting Medicare to the APA would bind persons hearing appeals and rendering decisions only to the statutes and regulations published in accordance with the APA. This too is an important due process protection. It will eliminate the practice of hearing officers relying on unpublished letters and manual instructions as the basis for decision.

2. Medicare must establish a formal system for reporting administrative decisions short of judicial review. Beneficiaries and providers need to know the parameters of Medicare rules and regulations. Only by reviewing the decisions of hearing officers, ALJs, etc. on a case by case

basis can the administration of Medicare truly become national in scope. As hospitals, physicians and PROs make decisions on beneficiaries and providers' claims, they should be collected and reported for their precedential value.

3. HHS should establish more stringent claims processing standards to prevent underpayment of beneficiary claims.

4. HHS should consider how well carriers and intermediaries review and resolve discrepancies in claims and how often their decisions are reversed on appeal as part of the carriers and intermediaries' evaluation of performance for continuing their contract with the Medicare program.

B. Recommendations: Part B

Congress should abandon the current carrier fair hearing process. Disputes regarding determination of entitlement to benefits and the amount of benefits should be heard by an Administrative Law Judge (ALJ). Where the amount in controversy is $1,000 or more, then the decision of the ALJ should be subject to judicial review.

AARP supports Senators Durenberger, Chafee and Heinz's bill, S. 1552 -- the Fair Medicare Appeals Act of 1985. Although this bill retains the carrier fair hearing process for all claims under $500, it provides due process protections not now available under Part B. Moreover, it permits, at the beneficiaries' discretion, the provider to represent the beneficiary. More often than not, providers are in the best position to know and understand Medicare law and represent the interests of the beneficiaries.

C. Recommendations: Continued Stay Denials Under Part A

1. PRO review of physician-initiated discharges is surely within the scope of the PRO statute, which authorizes PROs to "review some or all of the professional activities...for the purpose of determining whether such services are or were reasonable and medically necessary and whether such services and items are not allowable" under Medicare. The medical establishment itself is concerned over the premature discharge problem and thus must not believe that the Hippocratic oath and threat of malpractice suits are sufficient restraints on the pressures to discharge early.

2. The patient or his representative should receive notice of appeal rights at time of admission and that notice should be renewed when the patient is advised of possible discharge. Such notice would help offset the increasing institutional pressures for reduced treatment and early discharge. First, the mere fact that such notice is given might restrain providers and practioners from ordering early discharge. Second, if the patient knows he has an appeal right, he may be more assertive and successful in acquiring information on the course of treatment and prognosis. Finally, and most important, he may be able to obtain a meaningful review. The Kentucky PRO, for example, has "nearly always" sided in favor of continued hospital stay when the hospital wants to discharge but the attending physician does not.

3. The "notice of noncoverage" issued to the patient by the hospital should inform the patient when the physician opposes the discharge that will ensue. When the attending physician concurs with the discharge, the model letters prepared by HCFA suggest that the following should be included: "Your attending physician has been advised and has agreed with the hospital's decision that your further hospitalization is not necessary." When the physician disagrees, however, HCFA's model letter announces instead that the PRO concurs in the discharge decision, adding only: "We have advised your attending physician of the denial of further inpatient hospital care. You should discuss with your attending physician other arrangements for any further health care you may require." If the patient is to be told when the physician and the PRO agree with the discharge, the patient similarly should receive notice of the physician's opposition.

4. At the very minimum, the patient should receive a PRO review of a continued stay denial within 48 hours of making the request. A hospital may request an expedited review by the PRO when the attending physician does not concur with the hospital's decision that further hospitalization is not necessary. This review must take place within 48 hours. The beneficiary, faced with the same need for an expedited review, must wait at least three working days for the PRO's review of the noncoverage decision.

5. The kind of hearing provided to the beneficiary before

discharge should be given further consideration. The current regulations require a purely paper hearing, with no opportunity for oral presentation. There is something disturbing about the requirement that the PRO reviewer consult with the attending physician, but not permit the patient to be heard.

6. Further consideration should also be given to the basic structure of the continued stay appeals process. PROs are evaluated on the basis of their meeting certain targets for reduced services under their contracts with HCFA. Although HCFA has denied that PROs must satisfy quotas, the statute states that "the Secretary shall include in the (PRO) contract negotiated objectives against which the organizations' performance will be judged". The incentives built-in to PRO contracts cannot be disregarded. AARP believes that beneficiaries, providers and PROs must develop an appeals mechanism that protects the rights of Medicare patients.

CONCLUSION

The Medicare program is experiencing much needed change. In the enthusiasm for controlling spending, however, we cannot ignore the real world consequences of the incentives that have been unleashed. The recommendations outlined in this testimony provide an essential mechanism to assure beneficiaries and providers that the quest for cost containment will not be at the expense of quality of care afforded Medicare patients or at the perversion of notions of basic fairness in handling Medicare claims.

Thank you again, Mr. Chairman, for the opportunity to bring these important issues into the scrutiny of public debate.

STATEMENT OF ARLENE LAPP, MEDICARE BENEFICIARY, PORTLAND, OR, ACCOMPANIED BY BRUCE FRIED, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, WASHINGTON, DC

Ms. **Lapp**. Good morning.

My name is Arlene Lapp, and I am a resident of Portland, OR. I want to express my thanks to the chairman for permitting me the opportunity to appear before the committee today.

I have traveled to Washington to tell the members of this committee the problems I have had with Medicare part B and with the appeals system, or, to be more accurate, the lack of an appeals system for part B.

Accompanying me is Bruce Fried, an attorney at the National Senior Citizens Law Center in Washington, DC, who will serve as my counsel during these hearings. In this prepared testimony, I will address, with Mr. Fried's assistance, the need for increased safeguards in the Medicare part B appeals system.

I would like to say at the onset that I do not expect my appearance here before the committee to have an impact on my case; I am here in the hope that your consideration of my situation will result in modifications to the current part B appeals system sc that others will not experience the frustration, the futility, and the ultimate unfairness that I did.

The background of my medical problem is important to an understanding of the arbitrariness that I encountered in the Medicare part B appeals system. On July 27, 1982, I had a bilateral simple mastectomy, after having been diagnosed as having breast cancer. After several months I came to realize that I could not accept the loss of my breasts or the disfiguration of my body. After conferring with my physicians, breast reconstruction began.

At this point, it would be helpful to note: "Breast reconstruction following mastectomy is considered a relatively safe and effective noncosmetic procedure. Accordingly, Medicare Program payment may be made for this procedure." This has been Medicare policy since May 15, 1980. See the Medicare Carriers Manual.

Also, it should be understood that breast reconstruction is a several-step process, at least involving the implant of prosthesis, with the subsequent reconstruction of the nipple and the areolae.

My problems with the appeals system began at the time that my nipple reconstruction occurred. Prior to undergoing this procedure, I contacted the part B Medicare carrier in Oregon to be certain that Medicare would cover it. I was assured that the procedure would be covered since the surgery was a direct result of my cancer and would not be considered cosmetic.

Imagine my shock, and my frustration, I may add when I was informed that part A reimbursement for the hospital costs for this procedure was being denied by the fiscal intermediary. The basis of that denial was that the nipple reconstruction was "cosmetic surgery." As this was a part A issue, I was able to appeal the initial denial to an administrative law judge. I submitted a letter from my physician to the ALJ which detailed the need for the procedure and which convinced the ALJ that the procedure was not cosmetic but rather was required to improve the functioning of a malformed body member, following surgery. The ALJ decided that hospital costs would be reimbursed under Medicare part A.

It is also noteworthy that the anesthesiologist who attended me during the nipple reconstruction surgery was reimbursed by the Medicare part B carrier.

Even though the hospital costs and the anesthesiologist's costs for this second stage of my breast reconstruction were covered, the carrier initially determined that the surgeon's costs, some $1,800, would not be reimbursed because this stage of my breast reconstruction was "cosmetic." I asked the carrier to reconsider its decision, but it still decided to deny any reimbursement.

The reality of my having had cancer and the loss of my breasts was physically and emotionally devastating. The need to confront this insane denial of Medicare coverage forced me to relive this time in my life over and over again. It has been extremely painful and certainly did not contribute to my recovery. Still, given my family's financial situation, we had no choice but to pursue the only appeal that was available to us.

I requested a hearing before the carrier hearing officer. On February 6, 1985, the hearing was held. At that time I testified regarding the fact that the second stage of my breast reconstruction was not cosmetic, and I submitted several documents from my physicians supporting the fact that this procedure was not cosmetic. Also, I gave the hearing officer a copy of the ALJ's decision, where it was determined that the part A costs of this procedure would be reimbursed, since the procedure was not cosmetic.

The hearing officer rendered his decision on February 13, 1985. I have attached a copy of this decision, which includes the ALJ's opinion and physicians' letters, to the testimony I submitted for the record. It appears from the decision that the hearing officer contacted the medical staff at the carrier, and the medical review staff at the carrier's home office in Hartford, CT, after the hearing.

I understand from my attorney that such contact is known as "ex parte communication." It is strictly forbidden in normal judicial proceedings. All that I know is that some nameless, faceless persons were consulted by the hearing officer regarding my claim. I was never given the opportunity to know what those persons said, to ask them questions, or to present information to counter what they said, to counter their decision.

The hearing officer determined, after this communication, that the reimbursement for nipple reconstruction at the second stage of breast reconstruction after mastectomy would be permitted only if the ability to lactate would be restored. Such a narrow analysis is just plain ridiculous, ignores the simple fact that virtually all women who participate in the Medicare Program are at an age when lactation will never again occur, and ignores the psychological, the sexual, and the self-esteem value of the complete breast reconstruction.

If I had the right to further pursue any appeal of this decision, I would. It is a decision that I am certain is wrong, that an administrative law judge has determined is wrong, that my physicians tell me is wrong medically, and that my attorney tells me is wrong legally. And yet, this decision that so many believe to be wrong, and if not wrong then at least in need of further review, is unreviewable. If there is one certain wrong in this mess, that is it.

It is just inconceivable to me that I and other part B beneficiaries should be the only people with health insurance in the United States with no right to have a decision regarding insurance payment reviewed by a court. This would assure the kind of fairness all of us expect in these situations. Where there are large amounts of money at stake, as in my case, I believe that having the matter considered by an administrative law judge would be better than the carrier hearing officer. It was clear to me that the hearing officer in my case was substantially influenced by his conversations with carrier employees outside my presence. Such a thing would not occur with the ALJ. The ALJ would, I believe, be more independent and better trained and could, as a result, render a fairer decision.

I understand that S. 1551, introduced by Senators Durenberger, Heinz, and Chafee, would provide for just such a system of judicial review and the ALJ hearings. I hope that the problems I have experienced will serve as a sufficient example of the deficiencies in the current system, and the need to amend the system as provided in S. 1551.

And I sincerely hope that this bill does get where it should to help thousands of people in the United States that are denied their rights and are intimidated.

Senator **Durenberger**. Thank you very much.

Leonard.

[Ms. Lapp's written testimony follows:]

TESTIMONY

OF

ARLENE LAPP
OF
PORTLAND, OREGON

AND

BRUCE M. FRIED
OF THE
NATIONAL SENIOR CITIZENS LAW CENTER

BEFORE

THE SUBCOMMITTEE ON HEALTH

OF

THE COMMITTEE ON FINANCE

UNITED STATES SENATE

NOVEMBER 1, 1985

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My name is Arlene Lapp. I am a resident of Portland, Oregon. I want to express my thanks to the Chairman for permiting me the opportunity to appear before the Committee today. I have traveled to Washington to tell the members of this committee of the problems I have had with Medicare Part B, and with the apppeals system, or, to be more accurate, the lack of an appeals system for Part B.

Accompanying me is Bruce Fried. Mr. Fried is an attorney at the National Senior Citizens Law Center in Washington, D.C. and will serve as my counsel during these hearings. In this prepared testimony I will address, with Mr. Fried's assistance, the need for increased safeguards in the Medicare Part B appeals system. In addition, Mr. Fried will focus on other Medicare appeals issues that affect beneficiaries.

THE PART B APPEAL OF ARLENE LAPP

I would like to say at the outset that I do not expect my appearance before the Committee to have any impact on my case. I am here in the hope that your consideration of my situation will result in modifications to the current Part B appeals system so that others will not experience the frustration, futility, and ultimate unfairness that I did.

The background of my medical problem is important to an understanding of the arbitrariness that I encountered in the Medicare Part B appeals system. On July 27, 1982, I had a bilateral simple mastectomy, after having been diagnosed as having breast cancer. After several months I came to realize I could not accept the loss of my breasts or the disfiguration of my body. After conferring with my physicians, breast reconstruction began.

At this point it would be helpful to note that,

> "Breast reconstruction following mastectomy is considered a relatively safe and effective noncosmetic procedure. Accordingly, [Medicare] program payment may be made for this procedure."

This has been Medicare policy since May 15, 1980. See, Medicare Carriers Manual, HIM-14, Coverage Issues Appendix, §35-47.

Also, it should be understood that breast reconstruction is a several step process, at least involving the implant of prosthesis, with the subsequent reconstruction of the nipples and areolae.

My problems with the appeals system began at the time that my nipple reconstruction occurred. Prior to undergoing this procedure, I contacted the Part B Carrier in Oregon to be certain that Medicare would cover it. I was assured that the procedure would be covered since the surgery was a direct result of my cancer and would not be considered cosmetic.

Imagine my shock when I was informed that Part A reimbursement for the hospital costs for this procedure were being denied by the Fiscal Intermediary. The basis of that denial was that the nipple reconstruction was "cosmetic surgery." As this was a Part A issue, I was able to appeal the initial denial to an Administrative Law Judge (ALJ). I submitted a letter from my physician to the ALJ which detailed the need for the procedure, and which convinced the ALJ that the procedure was not "cosmetic", but rather was required to improve the functioning of a malformed body member, following surgery. The ALJ decided that hospital costs would be reimbursed under Medicare Part A.

It is also noteworthy that the anesthesiologist who attended me during the nipple reconstruction surgery was reimbursed by the Part B Carrier.

Even though the hospital costs, and anesthesiologists cost, for this second stage of my breast reconstruction were covered, the Carrier initially determined that the surgeon's costs, some $1,800, would not be reimbursed because this stage of my breast reconstruction was "cosmetic." I asked the carrier to reconsider its decision, but it still decided to deny any reimbursement.

The reality of having cancer, and the loss of my breasts, was physically and emotionally devastating. The need to confront this insane denial of Medicare coverage forced me to relive this time in my life over and over again. It has been extremely painful and certainly did not contribute to my recovery. Still, given my families financial situation, we had no choice but to pursue the only appeal that was available to us.

I requested a hearing before the Carrier Hearing Officer. On February 6, 1985, the hearing was held. At that time I testified regarding the fact that the second stage of my breast reconstruction was not cosmetic, and I submitted several documents from my physicians supporting the fact that this procedure was not cosmetic. Also, I gave the Hearing Officer a copy of the ALJ's decision were it was determined that the Part A costs of this procedure would be reimbursed since the procedure was not cosmetic.

The Hearing Officer rendered his decision on February 13, 1985. I have attached a copy of the decision, which includes the ALJ opinion and physicians' letters, for the record. It appears from the decision that the Hearing Officer contacted the medical staff at the carrier, and the medical review staff at the carrier's home office in Hartford, Connecticut after the hearing.

I understand from my attorneys that such contact is known as ex parte communication, and is strictly forbidden in normal judicial proceedings. All that I know is that some nameless, faceless persons were consulted by the hearing officer regarding my claim, and I was never given the opportunity to know what those persons said, to ask them questions, or to present information to counter what they said.

From the Decision, the Hearing Officer determined, after his communications, that reimbursement for nipple reconstruction, as the second stage of breast reconstruction after mastectomy, would be permitted only if the ability to lactate would be restored. Such a narrow analysis is just plain ridiculous. Such an analysis cannot be found in the Medicare Carriers Manual, ignores the simple fact that virtually all women who participate in the Medicare program are at an age where lactation will never again occur, and ignores the psychological, sexual, and self-esteem value of complete breast reconstruction.

If I had the right to further pursue an appeal of this decision, I would. It is a decision that I am certain is wrong, that an Administrative Law Judge has determined is wrong, that my physicians tell me is wrong medically and that my attorneys tell me is wrong legally. And yet, this decision that so many believe to be wrong, and if not wrong then at least in need of further review, is unreviewable. If there is one certain wrong in this mess that is it.

It is just inconceivable to me that I, and other Part B beneficiaries, should be the only people with health insurance in the United States with no right to have a decision regarding insurance payment review by a Court. This would assure the kind of fairness all of us expect in these situations. Where there are large amounts of money at stake, as in my case, I believe that having the matter considered by an Administrative Law Judge would be better than the Carrier Hearing Officer. It was clear to me that the Hearing Officer in my case was substantially influenced by his conversations with carrier employees outside by presence. Such a thing would not occur with an ALJ. The ALJ would, I believe be more independent, and better trained and could as a result render fairer decisions.

I understand that S 1551, introduced by Senators Durenburger, Heinz, and Chaffee, would provide for just such a system of judicial review and ALJ hearings. I hope that the problems I experienced will serve as a sufficient example of the deficiencies in the current system and the need to amend the system as provided in S 1551.

APPEALS OF PART B CLAIMS DENIALS

By way of background, Medicare's Part B program, formally the Supplemental Medical Insurance program, provides coverage for doctors' services (inpatient and outpatient), medical equipment, outpatient hospital services, rural health clinic services, ambulance services, physical and occupational therapy and speech pathology. Generally, coverage is provided for care or services that are medically necessary. Medicare pays for 80% of what it determines to be the "reasonable" charge after the beneficiary has met the annual deductible ($75 for 1985). The beneficiary must also pay a 20% copayment for each claim, plus the difference between the "reasonable charge" and the actual charge, unless the provider or physician accepts assignment.

The current system for appealing Part B claims decisions, where a claim is denied in whole or in part, is unchanged since the Medicare program was enacted in 1965. Where a carrier (an insurance company that processes part B claims) has denied a claim in whole or in part, and where there is at least $100 in dispute[1], the beneficiary may request a hearing before a "Part B hearing officer." This officer is an employee of the the carrier whose decision he or she is reviewing. Regardless of the amount in controversy, and regardless of the hearing officers decision, the beneficiary has no right to have the matter reviewed by a federal court.

This limited review process, while outdated, was justified in its historical context. At the time of the original enactment of the Medicare program, the Congress expected that the payments made under the supplemental Part B program would be smaller that under the primary Part A program. Thus, it was the "carriers, not the Secretary, [who] would review beneficiary complaints regarding the amount of benefits, and the bill [did] not provide for judicial review of a determination concerning the amount of benefits under Part B where claims [would] probably be for substantially smaller amounts than under part A." S Rep No. 404, 89th Cong, 1st Sess, 54-55 (1965).

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[1] Disputes of less than $100 are subject to a carrier paper review.

The limited appeal rights available under Part B was reiterated in 1972 when Senator Bennett offered an amendment to clarify the unavailability of judicial review. As the Senator said, "The situations in which medicare [Part B] decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters...The proposed amendment would merely clarify the original intent of the law and prevent the overloading of the courts with trivial matters because the intent is considered unclear." 118 Cong Rec 33992 (1972).

In 1982 the Supreme Court considered the limited appeal rights under part B in United States v Erika, Inc., 456 US 201, 102 S Ct 1650. The Court reviewed the legislative history and found it clear that judicial review of Part B claims decisions was precluded by Congress.

The Supreme Court made it clear to all that if judicial review were to be afforded in Part B cases it would be the Congress that must act.

The Part B hearing officer system was reviewed in the case of McClure v Harris, 503 F.Supp. 409 (N.D.Ca.1980). In that case, the district court found several deficiencies with the Part B hearing system. For instance, the court found that the hearing officers, as a class, have their impartiality compromised by virtue of both prior involvement and pecuniary interest. They have been vicariously involved because they are appointed by and serve at the will of the carrier which has not only participated in the prior stages of each case, but has twice denied the claims (through internal reviews) which are the subject of the hearing. Officers could only rule in the beneficiaries' favor by directly overturning the carriers' decision. This problem was underscored when the court noted that most of the officers were former or current employees of the carrier. Such prior involvement raised a specter of partiality akin to that present where judges routinely disqualify themselves from hearing matters in which their former associates are involved. This risk of partiality was particularly of concern since the officers' incomes were entirely dependent upon the carriers' decisions regarding whether, and how often, to call upon their services. For these and other reasons the district court found the Part B hearing officers system to be violative of the beneficiaries' due process rights.

Subsequently, the decision in McClure v Harris was overturned by the Supreme Court in Schweiker v McClure, 456 US 188, 102 S Ct 1665 (1982). Essentially, the Court found that the record did not support the district court's finding. From the Supreme Courts view, the plaintiffs had failed to prove their case.

PART B APPEALS IN A MODERN CONTEXT

Without questioning the systemic impartiality of the Part B hearing officer system of review, it is unquestionable that the Medicare Part B system has experienced a change as revolutionary as that experienced under Part A by virtue of the Prospective Payment System (PPS). The PPS was enacted to revolutionize the Medicare reimbursement mechanism for hospital inpatient services under Part A.

Under PPS, hospitals are given an incentive to perform more efficiently and, thus, where possible are performing many services on an outpatient basis under part B. Many services once performed on an inpatient basis are also now being done in physicians offices. Indeed, the entire range of services being performed under Part B are far more complex and costly then just a few years ago. And, of course, a physicians' services, whether performed on an inpatient or outpatient basis, are covered under Part B.

Simply stated, Part B is a far more complex program, involving far larger sums of money, than it was twenty or ten or even five years ago. It can no longer be said that Part B disputes are all trivial or inconsequential, and thus do no warrant a more complete appeals process.

The Medicare program for all its computers, policy documents, and systems, is ultimately a human endeavor. Perhaps the largest such endeavor ever undertaken by man. In 1984 there were more than 175,000,000 Part B claims filed. Such a volume of filings, papers, decisions, internal reviews, and hearing officer decisions, dictates that inevitably there will be some cases in which a decision will be made that is simply wrong. For the beneficiary who wants to obtain court review of the wrong decision it is simply too bad.

At this point it would be instructive to consider several actual cases which serve to highlight the kinds of Part B cases which would benefit from an improved administrative hearing and judicial review system.

Example 1: Oregon

Mrs. A, a Social Security disability recipient, was informed by the insurance carrier that she would not be reimbursed for those back treatments that exceeded the number of visits allowed by the insurance carrier's guidelines. The beneficiary appealed the denial of some of her visits and the carrier's hearing officer ruled in her favor. So far so good.

However, the carrier continued to deny Mrs. A's benefits. Once again, Mrs. A appealed the carrier's denial for her back treatments. The same hearing officer heard this second appeal. Mrs. A and her doctor testified that if anything her condition was worse than in the first case. At the close of the case the hearing officer said he MIGHT ask for a consultants opinion. Mrs. A asked for a chance to review such an opinion and comment on it, which the officer agreed to.

Subsequently, the hearing officer denied Mrs. A's claim entirely. The basis of the denial was a consultant's opinion that Mrs. A never had a chance to see or comment on. Mrs. A asked the officer to reopen the case so she could review and comment on the consultant's opinion. The officer refused because "based on the consultant's opinion...additional review by [you or your doctor] would not be indicated." This clearly arbitrary decision can not be subjected to judicial review.

Example 2: California

In 1982, Mrs. B, an elderly claimant, underwent neurosurgery to relieve chronic headaches which she had suffered from for many years. The surgeon's bill for $6,000 was submitted to the carrier for payment. The carrier subsequently approved $1,510.80 for payment to the surgeon. There was no explanation given as to how this figure was reached. A request for reconsideration was made, and this time the carrier increased the approved amount to $1,888.90. The carrier explained only that the original determination was incorrect. So far the process had taken almost a year.

Mrs. B requested a hearing on her claim. At the hearing, almost a year and a half from the date of the surgery, Mrs. B asked that the basis of Medicare's determination be explained, and that the hearing be continued so that she could review the explanation and prepare her response. The hearing officer denied her requests.

Interestingly, the hearing officer had been in that position for only six months. Previously, he had been a claims examiner for the same carrier for 24 years.

The hearing officer advised Mrs. B that prior to the hearing he had consulted the carriers medical consultant, whom he had worked with for many years. The consultant, a general surgeon with no neurosurgery experience, had made the carrier's determination, and that was good enough for the officer. The consulting physician made no written report and did not appear at the hearing. When Mrs. B asked to question the medical consultant, the hearing officer told her such questioning was not part of a hearing.

This decision, involving a substantial amount of money, was made without explaining the basis of the decision, denied the claimant a chance to question the decision maker, was made using ex parte communication, and precluded the beneficiary from being able to present her side of the case. Of course, the claimant has no right to have the courts review this less than fair decision.

Example 3: New York

Mrs. C. is wholly dependent on a respirator to sustain her breathing. Without a standby respirator, her life is in danger should the primary respirator breakdown. Notwithstanding this clear example of medically necessary equipment, the carrier denied coverage based on a policy document from HHS that had never been officially published. The requested reconsideration was performed by the same individual that made the initial denial.

A hearing was requested. Mrs. C, through her attorney, requested an opportunity to question the carrier's medical consultant. This was denied by the officer in writing. Similarly, the attorney asked for the opportunity to examine other policy makers and documents that had weighed on this claim and that request was also denied.

Only by avoiding the hearing officer, and seeking direct intervention from the HCFA administrator's office, was Mrs. C able to have her stand-by respirator covered.

Example 4: New York

Over the period of a year, Mrs. D required four identical treatments from the same physician for vascular problems in her legs. The physician's bills were $750 for each treatment. For each treatment the carrier initially approved no more than $100. After reconsideration, two of the treatments were approved for $500, while two were not revised. At the hearing on one of the claims that was not increased, the hearing officer refused to alter the approved amount. When Mrs. D objected and advised that two other identical claims had been paid at a higher level, the hearing officer threatened to reopen those cases and reduce their approved amount if Mrs. D persisted in her objections.

Despite the fact the the same procedure, by the same physician, on the same patient, in the same year were paid at different rates, there is no way for Mrs. D to have the hearing officers decision reviewed.

Example 5: Maryland

The claimant, who suffered from a stroke and severe arthritis, was prescribed an electric wheel chair. The carrier approved only half the cost of the chair. At the hearing the officer questioned whether the claimant needed an electric wheel chair at all, though that was not the issue before the officer. As it turned out, once again ex parte communications had occurred.

While the question of medical necessity was ultimately resolved, the amount of reimbursement never was. Despite the claimant's producing evidence showing that electric wheel chairs are reimbursed at a higher level by several other carriers, the hearing officer refused to consider that evidence.

In each of these cases, the beneficiary sought review of claims denials involving substantial amounts of money. In each instance, these matters would likely have been more fairly resolved had they been considered by an ALJ. In any case, the right to have these matters reviewed by a court, to assure compliance with the Medicare statute, remains essential.

Incredible as it may be, Medicare Part B beneficiaries are the only health insureds in the country with no right to have a court enforce the terms of their health insurance.

PROVIDING IMPROVED ADMINISTRATIVE HEARINGS AND JUDICIAL REVIEW TO PART B BENEFICIARIES

S. 1551 will provide Part B beneficiaries with appeal rights similar to those now available to Part A beneficiaries and those Part B beneficiaries participating in Health Maintenance Organizations (HMOs). The bill provides that where there is at least $500 and less than

$1,000 in dispute[2] the beneficiary will be entitled to a hearing by an Administrative Law Judge under Part A and for Part B beneficiaries participating in HMOs there need only be $100 in dispute). Where the amount in dispute is at least $100 and less than $500 the matter would continue to be considered under the existing Part B hearing officer system. The bill provides that where there is at least $1,000 in dispute following an ALJ hearing the beneficiary may seek review from a federal district court (the same system of judicial review is currently available under Part A under Part A and for Part B beneficiaries participating in HMOs).

While S. 1551 will significantly improve the fairness of the Medicare system, it is expected to have only a small fiscal impact.

For 1982, 175 million claims were submitted under Part B. Approximately 20,000 of those claims were appealed to a carrier hearing officer. Available statistical information shows that approximately 50%, or 10,000, of those claims had amounts in dispute of $500 or more, and that 20-25%, or at most 5,000, of those claims had amounts in dispute of $1,000 or more.

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[2] The committee may wish to consider deleleting the upper limit on ALJ reviews. If not eliminated, beneficiaries with more than $1,000 would be unable to obtain any administrative appeal. Since the bill permits persons with more than $1,000 in dispute to have ALJ decisions appealed to federal court, this problem is apparently inadvertant.

Under S. 1551 half of the Part B claims appealed, those with less than $500 in dispute, would be considered under the existing Part B hearing officer system. The other half, those involving larger sums, would be referred to ALJs.[3] Since the ALJs will be substituted for the hearing officers there would not be a duplication of cost. The savings realized by having half as many Part B hearing officer hearings would be used to pay for the ALJ hearing. An analysis of ALJ hearing and hearing officer hearing cost data shows that a Part B hearing officer hearing and an ALJ hearing have approximately the same cost. Even if the direct cost of an ALJ hearing is slightly more, the savings realized by having a more rational, more certain claims process will greatly offset any additional cost.

Given the comparatively inconsequential cost of providing these improved fairness procedures, there is simply no reason to continue to deny Part B beneficiaries with significant amounts in dispute access to high quality ALJ hearings and judicial review.

ASSURING BENEFICIARIES THE RIGHT TO THE REPRESENTATIVE OF THEIR CHOICE.

As anyone who has examined the Medicare system is aware, it is as complex a system and mindboggling a process as man could create. There is little doubt that virtually all beneficiaries confronting a Medicare dispute require assistance in order to most effectively pursue their rights or interests. Among the most effective representatives of beneficiaries have been providers or suppliers. In most instances there is simply no other entity or individual that understands the Medicare program or the beneficiaries particular medical needs as well as the provider of the care.

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[3] Assuming the $1,000 amount in dispute ceiling on ALJ jurisdiction is removed.

In 1984, the administration changed 18 years of policy by prohibiting Part A providers from representing beneficiaries in appeals. The ostensible reason was that there might be a conflict of interest between the beneficiary and the provider.

A careful review of provider and beneficiary relations does not reveal where such a conflict might arise. Even if a conflict exists in limited circumstances or with regard to an individual case, it is simply wrong for the administration to deny all beneficiaries free choice in selecting a representative.

S. 1551 makes it clear that the beneficiary may have as a representative any entity or individual he or she chooses, without restricting that choice solely because the representative is a provider of services.

These matters, while significant and requiring prompt attention, are merely two of a number of due process and fairness problems present in the Medicare program.

These issues are the simplest and most straightforward of the problems faced by individuals and organizations participating in Medicare. The problems of arbitrariness and capriciousness, of administrative expediency and programmatic irrationality serve to undermine everyones support of this most important health care system.

NOTICE AND APPEAL PROBLEMS IN THE PROSPECTIVE PAYMENT SYSTEM: PROVIDING A MECHANISM TO PREVENT PREMATURE DISCHARGES

While there may be a dispute regarding frequency, there is no doubt that some number of Medicare beneficiaries have been prematurely discharged from hospitals. While nothing is gained at this juncture by pointing fingers or assigning blame, it is critical that steps be taken to prevent even one additional occurence of this misapplication of the Prospective Payment System (PPS).

One approach to preventing premature discharge would be to require that all beneficiaries who enter a hospital receive basic information regarding PPS, its operation, what can be expected the time the beneficiary is ready to be discharged, and the mechanisms available to appeal decisions regarding the medical necessity of continued hospital care. There are several efforts underway to educate beneficiaries about the PPS and patient rights. While important, it is likely that this information will be forgotten unless it is also provided at the point the beneficiary becomes personally involved in the PPS.

Under current PPS regulations, if a hospital intends to charge an individual after their hospital care is no longer medically necessary, the hospital must give that individual written notice, two days prior to the time when such care is no longer medically necessary. See, 42 CFR § 412.42 (c). If there is no intention to charge the beneficiary, than no notice need be given regarding an anticipated time of discharge.

At least in part as a result of this narrow notice requirement, many Medicare patients are not receiving sufficient notice regarding the hospital's determination that their stay in no longer medically necessary, or their physician's intention to discharge them, or basic information regarding appealing those decisions to the Peer Review Organization (PRO).

If written notice were required to be given to all Medicare beneficiaries, at least two days prior to discharge or the date when in-patient care is no longer medically necessary, many patients would receive information they are not now receiving. Of course, such a notice should include information regarding how to reach and appeal those decision to a PRO.

Finally, PROs must be obligated to expeditiously consider, investigate, and decide beneficiary appeals of discharge or medical necessity determination. Since the current notice of medical neccesity determination need only be given two days in advance, and since the PRO may take three working days to decide an appeal, there is a strong incentive for beneficiaries to leave the hospital rather than expose themselves to fiscal liability.

Even if the beneficiary requests a PRO review immediately upon receipt of the notice (an unlikely occurence for a severely ill older person), the PRO would not have to make a decision until after the hospital-determined date of loss of medical necessity had been reached. Thus, from one to three days of fiscal liability could confront the beneficiary. Exposure to such liability will be a strong incentive to leave the hospital, even where leaving may jeopardize the individual's recovery or life.

In order to assure a meaningful opportunity to receive PRO review in these cases, the PROs should be requried to render a decision on such an appeal within 24 hours of the appeal being received.

APPLICATION OF ADMINISTRATIVE PROCEDURE ACT STANDARDS TO MEDICARE

The Administrative Procedure Act (APA), 5 USC §553, provides that the requirements of the notice and comment rule-making do not apply to federal benefit programs. During his tenure as Secretary of Health, Education and Welfare, Elliot Richardson voluntarily bound HEW to comply with those provisions of the APA. The Secretary of Health and Human Services published a Notice of

Proposed Rule Making (NPRM) in 1981 stating his intention to no longer be bound by the APA. While no final rule has been published, neither has the Secretary withdrawn the NPRM. The Committee may wish to consider legislation that would bind the Secretary, at least in the context of the Medicare program, to comply with the rule-making requirements of the APA.

A related problem exists with regard to the application of agency policies that have not been subjected to APA rulemaking, or which are contrary to policies properly promulgated pursuant to the APA. A similar problem was found to exist in the disability programs of the Social Security Administration (SSA). Essentially, persons hearing appeals and rendering decisions on eligibility and payments were applying agency policies that were improperly promulgated, or contravened the statute or regulations.

In response, the Congress directed that, with regard the disability programs, only those policies promulgated pursuant to the APA would be binding at any level of review. See, Social Security Disability Reform Act of 1984, Public Law 98-460, §9. Similar legislation, particularly focused on the Medicare program, is in order to assure that fiscal intermediaries, carriers, hearing officers, and ALJs are bound to apply policies promulgated pursuant to the APA.

CONCLUSION

A Medicare program that is fair, that allows for meaningful administrative appeals and the right to judicial review, that is predictable, rational, and objective without meaningless bureaucratic hurdles is, ultimately, in everyones best interest. Enactment of S. 1551 is a step is achieveing that goal. Attention to the issues also discussed above is equally urgent. Thank you for your consideration.

MEDICARE FAIR HEARING DECISION

ENROLLEE Arlene LAPP

HEALTH INSURANCE CLAIM NUMBER 516-28-8256 A

REPRESENTATIVEs Elwood Lapp (husband), and Rhonda Schmidt

ASSIGNEE None

CARRIER — ÆTNA LIFE INSURANCE COMPANY

CITY Portland, Oregon

STENOGRAPHIC RECORD MADE BY Tape Recorder

PLACE OF HEARING Portland, Oregon

DATE February 6, 1985

THE ISSUE

Did AEtna Life Insurance Company, hereinafter referred to as the carrier, properly allow benefits for the following services in question:

PHYSICIAN	DATE	TYPE OF SERVICE	CHARGE	ALLOWED
Christopher W. Hauge, M. D.	4-10-84	Bilateral Areolear Nipple Reconstruction	$1600.00	0
	4-10-84	Grafting From Two Areas	200.00	0

The total charges to be considered at this hearing are $1800. The total approved by the carrier to date is Zero. The amount in controversy is then $1440.00 ($1800.00 disallowed less the 20 percent coinsurance of $360.00).

FINDINGS OF FACT

The carrier's file reflects that the beneficiary, Mrs. LAPP, was suffering from the effects of status post bilateral mastectomy for inteabuctal carcinoma. She had previously undergone bilateral breast reconstruction, first stage with placement of submuscular breast prosthesis.

Claims for services rendered were submitted by the beneficiary in a timely manner. Being dissatisfied with the carrier's original determination, which disallowed all benefit consideration, a request for review was filed on August 12, 1984. When the carrier upheld their original determination, a request for a hearing was submitted on December 26, 1984.

APPLICABLE LAW, REGULATIONS AND GOVERNMENTAL DIRECTIVES

Section 1842 (b) (3) (C) of Title XVIII of the Social Security Act states that (carriers) "will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy."

Section 1862 (a) (10) of Title XVIII of the Social Security Act states under Exclusions from Coverage: "Notwithstanding any other provisions of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member."

Section 2329 of the Medicare Carriers Manual states in pertinent part: "Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e, as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair, of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also services some cosmetic purpose."

Section 2303 of the Medicare Carriers Manual, under its General Exclusion, states in part: "Items and services which are not reasonable and necessary for the diagnosis, or treatment of illness or injury, or to improve the functioning of a malformed body member, are not reimbursible under the Program."

Section 3300 of the same manual states: "Expenses for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are excluded from coverage under both Part A and Part B of the Program. Carriers have the authority and responsibility to determine, in a given case, whether a claim is for a covered service and to deny claims for noncovered or excluded items or services. In addition, carriers are to assist in the application of safeguards against unnecessary utilization of services furnished eligible individuals."

EVALUATION OF THE RECORD

In addition to the Applicable Law, Regulations and Governmental Directives the following documents have been examined as one aspect of the conduct of the hearing:

1. The Health Insurance Claim form for services rendered dated May 9, 1984.
2. The operative report at Good Samaritan Hospital for the surgery at issue, dated April 10, 1984.
3. The admitting history and physical examination for this confinement, dated April 9, 1984.
4. Exhibit I, the beneficiary's written statement, dated February 6, 1985.
5. Exhibit II, the ruling of the Administrative Law Judge, dated February 17, 1984, signed by Charles Evans.

6. Exhibit III, a recent letter from Dr. Hauge, dated February 3, 1985 elaborating on the originating surgeries and then the bilateral nipple reconstruction.

7. Postoperative photographs (4) submitted at the time of the hearing.

8. Previous correspondence from Dr. Hauge, dated August 30, 1983 and December 4, 1984.

9. Dr. Philip Snedecor's letter of August 18, 1983.

FINAL DECISION

After a thorough review of all pertinent documentation in this case, including claim forms, correspondence, and testimony of the beneficiary, her daughter and her husband, in light of governmental directives concerning the carrier's denial of this claim as cosmetic surgery, it is my determination that the carrier complied with all governmental law regulations and policies concerning this surgery.

The documentation submitted prior to the date of this service concerned itself with other actions concerning the bilateral mastectomies and prosthetic repair of the surgical site. The testimony received as well as the documentation submitted into evidence, makes the claim that the nipple reconstruction bilaterally is only a part of the total reconstructive process, and should be included in the overall coverage affored previously, and upheld by the Administrative Law Judge's determination. This contention must be dismissed in light of the governmental directives concerning cosmetic surgery and also taking into consideration the carrier's medical consultant's opinion. This opinion, challenged by the beneficiary and her representatives, because the carrier's consultant is not a plastic or a general surgeon, states in toto: "Cosmetic. There is no functional improvement to the breast from this procedure." Although Dr. Price is not a surgeon, he is the carrier's primary consultant and reviews all types, of services, including the surgeries. His opinion is then accepted.

To further provide this beneficiary her due process, I discussed this case with the carrier's medical staff on February 7, 1985. It was the registered nurse's opinion that this procedure cannot be considered restorative and does not provide for the improvement of a malfunctioning bodily member. In other words, to improve the malfunctioning of the breast, by nipple reconstruction, would provide for the ability to lactate. In further discussions with medical review personnel in the carrier's home office of Hartford, Connecticut, their superintendent for medical review, agreed with this position. The surgery must be construed as cosmetic, as the nipples are not a functioning component of the breast prosthesis.

The beneficiary and the representatives' contention that this surgical procedure compares favorably with the replacement of severed fingers to the hand, then does not strike a correct parallel.

The carrier's actions are then affirmed, and no benefits are payable on this claim. As future surgery is indicated in the testimony and evidence submitted, this hearing officer cannot prejudge benefit determination, and will not comment on the coverage or noncoverage of future surgeries to the breast and/or nipples.

Under the authority provided in Section 405.835 of Regulation No. 5, Federal Health Insurance for the Aged and Disabled, I hold this decision binding upon all interested parties.

February 13, 1985

A. Charles Waterman
Senior Hearing Officer
AEtna Life Insurance Company

c: Medicare Administration, Portland, OR.

EXHIBIT I

MEDICARE PART B HEARING

My name is Arlene B. Lapp. This is my written statement dated February 6, 1985, which I shall now read to all members present at this hearing.

On July 13, 1982 I was diagnosed by Dr. Phillip Snedecor as having intraductal cancer of the left breast. Because I had a history of multiple breast biopsies, prior to my diagnosis of cancer, Dr. Snedecor advised me to have not only my left breast removed but the right breast as well. A bilateral simple mastectomy was performed on July 27, 1982.

After a period of months I came to realize I could not accept the loss of my breasts or the disfiguration of my body. After a discussion with Dr. Snedecor it was determined that for my well being that I have breast reconstruction. Dr. Snedecor recommended that I see Dr. Christopher Hauge.

On December 27, 1982, first stage reconstruction was begun by Dr. Hauge and at that time a gell filled prosthesis was placed bilaterally.

In July of 1983 I was found to have very dense scar tissue of the chest wall. Dr. Hauge then tried injections of intralesional cortisone. Unfortunatley I developed capsular contractures which did not provide adequate or satisfactory breast recontruction. In short, the surgery was a failure.

On July 11, 1983 a second surgery was performed and the contractures were released and new prosthesis were put in place. This tecnique allowed expansion of the mammary mounds and would lead to a much more satisfactory breast reconstruction.

Please refer to the last paragraph of Dr.Hauge's letter dated August 30, 1983 if you need his statement concerning the non-cosmetic nature of this surgery.

In March of 1984, Dr. Hauge felt I was ready for the second stage of my breast reconstruction, which was nipple and areolea construction. I had my surgery on April 10, 1984. It is this stage of my reconstruction that this particular hearing refers to.

Before each of my surgeries I have called Medi-Care and asked if the procedure was covered. Each time I have been assured that I was indeed covered because of the fact that I have had breast cancer and these surgeries are a direct result of my cancer and are not cosmetic. Medi-Care has paid the anesthesiologist and the hospital for my surgery in April of 1984. It should follow that the doctors bill would be covered if the hospital and anesthsiologists bills were paid by Medi-Care for the same surgery.

This is the second time I have been asked to defend my claim for medical coverage by Medi-Care. Last time they paid the doctor and anesthsiologist but not the hospital.

Please refer to your copy of judge Charles S. Evans ruling dated February 17,1984. As you can see Judge Evans ruled in my favor and I quote (page 3) "It is unclear from the record whether the medicare intermediary had the benefit of Dr. Hauge's explanation for the procedures, but in any event that explanation, in the mind of the undersigned persuasively establishes that the procedures here were not "cosmetic". Rather, the procedures were required to improve the functioning of a malformed body member,namely the claimant's breast following bilateral mastectomy." "Since coverage was given for the first stage of the reconstructive process, it only follows that the coverage should be allowed for the follow up procedures which from all evidence of the record were medically required and were not merely cosmetic in nature." On page 2 under the EVALUATION OF THE EVIDENCE I would like to quote a paragraph.

"The purpose of such breast reconstruction is not "cosmetic" in nature, but is required as adjunct to a mastectomy procedure to restore the patient as nearly as possible to the condition prior to the initial surgery."

I fail to understand medicare's position concerning my cancer and breast reconstruction. The continual harrasment by this organization has been most unpleasant and I assure you it has not helped my physical or emotional recovery from the devestating effects of breast cancer. I feel I have been discriminated against because of my need to depend on medicare for my health expenses. To re-live this time in my life over and over again is extremely painful and certainley does not help my recovery. I have been straight forward ane honest and medicare has made me feel like I am asking for something above and beyond the need to simpley get on with my life. Let us hope this hearing today can clear the way for a final solution for this situation.

I have brought my daughter and husband with me today as witnesses for my case. Please ask them for further testamony if needed.

My breast reconstruction is still continuing and I sincerely hope I do not have to appear before you again. Surely your time could be better spent reviewing cases that have not already been heard before. Especially when the Judge has given a ruling favorable for the claiment! After all money is the issue here and time is money!

In closing I would like to give you another letter from Dr. Hauge concerning my on going treatment. Enclosed you will find pictures of my current stage of breast reconstruction. As you can plainly see, this is not "cosmetic" surgery.

Thankyou

Arlene B. Kapp

EXHIBIT II

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS
522 SW 5th, Suite 601
Portland, OR 97204

Name and Address of Claimant

Arlene B. Lapp
3165 N.E. 86th
Portland, OR 97220

NOTICE OF FAVORABLE DECISION
PLEASE READ CAREFULLY

The enclosed decision is favorable to you, either wholly or partly. If you are satisfied with the decision, there is no need for you to contact the hearing office or the Social Security office. You will be notified as soon as action on the decision has been completed.

If you disagree with the decision, you have the right to request the Appeals Council to review it within 60 days from the date of receipt of the notice of this decision. It will be presumed that this notice is received within 5 days after the date shown below, unless a reasonable showing is made otherwise. You (or your representative) may file a request for review at your local Social Security office or at the hearing office, or you may write to these offices indicating your intent to request review. You may also mail the request for review directly to the Appeals Council, Office of Hearings and Appeals, SSA, P.O. Box 2518, Washington, D.C. 20013

The Appeals Council may, on its own motion, within 60 days from the date shown below, review the decision, which could possibly result in a change in the decision (20 CFR 404.969 and 416.1469) After the 60-day period, the Appeals Council generally may only reopen and revise the decision on the basis of new and material evidence, or if a clerical error has been made as to the amount of the benefits or where there is an error as to the decision on the face of the evidence on which it is based (20 CFR 404.988 and 416.1488, 42 CFR 405.750 and 405.1570). If the Appeals Council decides to review the enclosed decision on its own motion or to reopen and revise it, you will be notified accordingly.

Unless you timely request review by the Appeals Council or the Council reviews the decision on its own initiative, you may not obtain a court review of your case (section 205(g), 1631(c)(3), or 1869(b) or the Social Security Act).

This notice and enclosed copy of
decision mailed
February 17, 1984

cc
~~Name and Address of Representative~~

BEST COPY AVAILABLE

NOTE TO PROCESSING CENTER:
FURTHER ACTION NECESSARY

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
OFFICE OF HEARINGS AND APPEALS

DECISION

IN THE CASE OF:	CLAIM FOR:
Arlene S. Lapp	Hospital Insurance Benefits
(Claimant)	516 28 8256
	(Social Security Number)

This case is before the Administrative Law Judge upon a timely request for hearing dated November 7, 1982. A prehearing review of the matter warranted a favorable decision on behalf of the claimant without taking additional testimony from her.

The general issue to be decided, in this case, is whether or not reimbursement can be made under Section 1812 of Title XVIII of the Social Security Act, as amended, for services provided to the claimant by Good Samaritan Hospital in Portland, Oregon, for the period of July 10, 1983 to July 14, 1983, or if such inpatient services are excluded from reimbursement by the application of specific issue to be resolved, if whether the claimant received care which was excluded for coverage as being "cosmetic".

LAW AND REGULATIONS

Section 1812 of Title XVIII of the Social Security Act, as amended, provides that payment may be made for inpatient hospital services when such services are required on an inpatient basis for an individual's medical treatment or for medically necessary diagnostic studies or procedures. Under this section of the law, an individual, because of his or her condition, must require the constant availability of doctors and complex medical equipment and services associated with the provision of hospital services generally provided only on an inpatient basis. Section 1862 of Title XVIII of the Act provides for exclusions from coverage of certain types of costs incurred for inpatient hospital care. This section of the law reads in pertinent part:

"(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services:

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;..."

EVALUATION OF THE EVIDENCE

The claimant, in this case, appealed the denial by the Medicare Intermediary denying coverage for Part A medicare inpatient hospital benefits for services rendered to her during a hospital admission at the Good Samaritan Hospital, in Portland, Oregon, from July 10, 1983 through July 14, 1983. Her claim for payment of these services was denied initially and upon reconsideration upon the basis that the services received were in connection with both "cosmetic surgery", not required for the prompt repair of an accidential injury, or for improvement of the functioning of a malformed body part.

The evidence shows that the claimant, who is a 52 year old female, was originally treated in December 1982, by Christopher Hauge, M.D., for an intraductal cancer of the left breast. She underwent a bilateral simple mastectomy followed by breast reconstruction procedures performed by Dr. Hauge in December of 1982. Following initial recovery from this procedure, the patient was found to have dense scar tissue in the chest wall and other complications requiring injections of cortisone; however, this therapy was not effective and she developed capsular contractures and rejection of the breast reconstruction. Therefore, she was readmitted to the hospital for revision and release of the capsular tissues. At this time, the previously placed prosthesis was removed and replaced by a larger prosthesis using a double-lumen 400cc gel. saline filled prosthesis. According to a letter by Dr. Hauge, dated August 30, 1983, and a similar communication by Phillip A. Snedecor, M.D., dated August 18, 1983, the claimant's reconstructive surgery was necessary to restore a normal feminine contour, and was required by the failure of the previous reconstructive maneuvers. (The purpose of such breast reconstruction is not cosmetic in nature, but is required as a adjunct to a mastectomy procedure to restore the patient as nearly as possible to the condition prior to the initial surgery.)

The medicare law Section 1862(a)(10) does provide a specific exclusion for expenses in connection with cosmetic surgery not required for the prompt repair of an accidental injury or for improvement of the functioning of a malformed body member. This provision is further elaborated by Regulations promulgated by the Secretary at 42 CFR 405.310(g). This section provides essentially the same exclusion. No other explanation is included in the law or regulations. In the initial review the medicare intermediary determined, without explanation, that the procedures here involved were cosmetic and therefore excluded under the aforementioned provision. It is unclear from the record whether the medicare intermediary had the benefit of Dr. Hauge's explanation for the procedures, but in any event that explanation, in the mind of the undersigned, persuasively establishes that procedures here were not cosmetic. Rather, the procedures were required to improve the functioning of a malformed body member, namely the claimant's breast following bilateral mastectomy. (It is noted that initially the medicare intermediary did approve payment for the first stage of the reconstructive procedures but denied coverage only for the latter procedure which was required when the initial operation failed to achieve the desired results. Since coverage was given for the first stage of the reconstructive process, it only follows that the coverage should be allowed for the follow up procedures which from all evidence of the record were medically required and were not merely cosmetic in nature.)

FINDINGS

After careful consideration of the entire record, the following specific findings are made:

1. The claimant was eligible for health insurance benefits under the Social Security Act, as amended.

2. The claimant is seeking reimbursement in excess of $100 and the Administrative Law Judge has jurisdiction of the claim.

3. The claimant was a patient at the Good Samaritan Hospital in Portland, Oregon, from July 10, 1983 to July 14, 1983.

4. The services received by the claimant during the hospital admission were required for the prompt repair of a malformed body part as a consequence of medically necessary surgical procedures.

5. The services rendered to the claimant, while a patient at the Good Samaritan Hospital, were required to be given on an inpatient basis.

DECISION

It is the decision of the Administrative Law Judge that payment of hospital insurance benefits under Title XVIII, of the Social Security Act, may be made on the claimant's behalf for the services furnished by the Good Samaritan Hospital from July 10, 1983 to July 14, 1983.

Charles S. Evans

Charles S. Evans
Administrative Law Judge

~~February 17, 1984~~
Date:

EXHIBIT III

CHRISTOPHER W. HAUGE, M.D., P.C.
Physician and Surgeon
Plastic and Reconstructive Surgery
Maxillo-Facial, Microvascular and Hand Surgery

2222 N.W. LOVEJOY SUITE 242 PORTLAND, OREGON 97210 TELEPHONE 223 068

February 3, 1985

Re: Arlene Lapp

To Whom It May Concern:

Mrs. Arlene Lapp is a 53-year-old Caucasian female who was first treated by myself in December, 1982 for breast reconstruction. The patient has a history of multiple breast biopsies, leading to a diagnosis of non-infiltrating intraductal cancer of the left breast which was made in 1982. The patient subsequently underwent bilateral simple mastectomy. First stage breast reconstruction was performed by myself on December 27, 1982. Postoperatively, the patient developed very dense scar tissue surrounding the prostheses. Keloid scars also developed as an unanticipated wound healing complication. This complication has been resolved with the use of multiple intralesional injections of steroids. The capsular contractures which the patient first developed were treated with open capsulotomy on July 11, 1983. At that time a larger prosthesis was placed. The patient has enjoyed much more satisfactory expansion, with the development of an adequate "mammary mound." On April 10, 1984 she underwent nipple-areolar reconstruction with the use of full thickness grafts from the groin region and full thickness composite grafts from the plantar aspects of the second toes. The areolar skin grafts have been quite successful. Unfortunately, she has had inadequate expansion of the papillary portion of the nipple.

In order to obtain the most satisfactory nipple reconstruction result, on lay grafting has been recommended to the patient. This would require a short hospitalization of approximately two days and a short operative procedure. The patient is interested in obtaining a better result. I feel her expectations are realistic. Further grafting would involve again the use of full thickness grafts from the lower extremities. Hopefully, this would be the final procedure and would lead to the most satisfactory result obtainable. Photographs are being sent for your review.

Sincerely yours,

Christopher W. Hauge, M.D.

CWH:mmf

August 30, 1983

Medicare

Re: Arlene Lapp

To Whom It May Concern:

Mrs. Arlene Lapp is a pleasant 52-year-old Caucasian female first treated by myself in December, 1982 for breast reconstruction. The patient had a history of having had multiple breast biopsies, prior to a positive biopsy of non-infiltrating intraductal cancer of the left breast in July, 1982. The patient subsequently underwent bilateral simple mastectomy. First stage breast reconstruction was performed by myself on December 27, 1982. At that time a double lumen saline-gel filled prosthesis was placed bilaterally, 300 cc prosthesis was utilized.

The patient was found to have very dense scar tissue of the chest wall and showed marked delay of the anticipated skin stretching. Scar tissue hypertrophy or keloid formation was noted, which required injections of intralesional cortisone. Unfortunately, the patient developed capsular contractures which did not provide adequate or satisfactory breast reconstruction.

These contractures were released by open capsulotomy techniques and larger prostheses placed on July 11, 1983. This technique allowed expansion of the mammary mounds and should lead to a much more satisfactory breast reconstruction.

These surgical procedures should not be considered cosmetic in any fashion. The purpose of breast reconstruction following mastectomy is to restore a normal feminine contour and not to improve upon a natural condition, which would be defined as "cosmetic." Following the destructive nature of a mastectomy with loss of body image, breast reconstruction done as staged maneuvers offer these individuals an important opportunity to look and feel more "normal." The purpose and results of this type of breast reconstruction cannot by any means be considered cosmetic.

Sincerely yours,

Christopher W. Hauge, M.D.

CWH:maf

CHRISTOPHER W. HAUGE, M.D., P.C.
Physician and Surgeon
Plastic and Reconstructive Surgery
Maxillo-Facial, Microvascular and Hand Surgery

2222 N.W. LOVEJOY SUITE 242 PORTLAND, OREGON 97210 TELEPHONE 223-0687

December 4, 1984

Medicare
1500 S.W. First
Portland, Oregon 97201

RE: Arlene Lapp
Enclosures

To Whom It May Concern:

I am writing concerning the above named patient and the enclosed information. At this time, I would like a review of the information submitted. I have enclosed a history and physical for your examination.

Your information states that this procedure was cosmetic in nature. I would like to inform you that reconstruction following a mastectomy is not a cosmetic procedure. Mrs. Lapp has had her breasts removed due to cancer, therefore her reconstruction is due to cancer not cosmetic reasons.

I hope this information will be helpful in re-evaluating her claim. Thank you for your attention to this matter.

Sincerely,

C.W. Hauge, M.D.

Christopher W. Hauge, M.D.

CWH:bb
Enclosures

SURGICAL ASSOCIATES

2222 N. W. Lovejoy Street – Suite 202
Portland, Oregon 97210
Telephone 229-7339

SURGEONS

Harvey W. Baker, M.D., P.C.
Philip A. Snedecor, M.D., P.C.
William C. Awe, M.D., P.C.
Larry R. Eidemiller, M.D., P.C.
C. Edwin Irish, M.D.

730-E. S.E. Oak
Hillsboro, Oregon 97123
Telephone: 640-6061

August 18, 1983

Re: Arlene Lapp

To Whom It May Concern,

On July 27, 1982 Mrs. Arlene Lapp had a bilateral simple mastectomy performed for intraductal carcinoma of the left breast and intraductal papillomatosis of the right breast diffuse. Her surgery was very necessary and because of good prognosis Mrs. Lapp was advised to have mammory implants performed which were done by Dr. Chris Hauge.

I hope this information is satisfactory please let me know if you have any questions.

Sincerely,

P A Snedecor

Phillip A. Snedecor, M.D.

PAS/ps

STATEMENT OF LEONARD LESSER, SPECIAL COUNSEL, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, DC

Mr. **Lesser**. Thank you, Senator.

My name is Leonard Lesser, and I am appearing on behalf of the National Council of Senior Citizens, which represents some 4½ million elderly, most of whom are beneficiaries under Medicare.

At this stage in the hearing I believe enough has been said to indicate the importance of the enactment of S. 1551. Since my statement is going to be made part of the record, I would like to make just a few points to really emphasize those things that have already been said.

First, let me just state, I see no reason why an elderly person who is a beneficiary under the Medicare system should not have the right to a fair hearing on the denial of a claim under part B, and the right to choose a representative of his own choosing in that appeal.

When the law was enacted, part B was treated differently than part A, as we all know, because claims under part B were assumed to be small and not warrant the expense of an appeal. Because of the flaws and many other reasons—the increases in technology, the inflationary increases in costs, and the shifting of care from in-hospital to out-hospital locations—the claims under part B have increased in magnitude.

Senator **Durenberger**. Plus, we are doing a lot of things we never did before.

Mr. **Lesser**. That is right.

Senator **Durenberger**. Through the medical technology, and the genius of doctors.

Mr. **Lesser**. And as a result, beneficiaries now pay 50 percent, about 50 percent of their total medical costs, out of their own pockets, in addition to those costs which are reimbursed under part B.

As a result, the denial of a claim under part B adds to what is already a tremendous burden on the beneficiary, and warrants the right to a fair hearing.

I think, as Mr. Pickering pointed out, a fair hearing does require a hearing before a person, an individual, who is impartial, not an employee of the carrier. It just seems to me this is something that just doesn't hold up in our system of affording due process to an individual.

Second, I think an individual should have the right to choose his own representative. We are not saying that the doctor or the provider should always be the representative; but, if the beneficiary feels that that individual's knowledge of the system, knowledge of the circumstances of his case, would make him an adequate representative, then he should have the right to so choose that individual.

In summary, Mr. Chairman, I would urge that the committee report out and the Senate enact promptly S. 1551. Thank you.

[Mr. Lesser's written testimony follows:]

The Medicare Appeals Process

Statement by

Leonard Lesser

National Council of Senior Citizens

before the

U.S. Senate Committee on Finance

Subcommittee on Health

November 1, 1985

Mr. Chairman, I am Leonard Lesser, Special Counsel to the National Council of Senior Citizens. The National Council represents over 4.5 million elderly individuals, the majority of whom are Medicare beneficiaries. For them, and for all Medicare enrollees who will benefit from improved fairness in the Medicare appeals process, we appreciate the opportunity to testify today.

Mr. Chairman, the Medicare program reached a milestone in July of this year when it began its third decade of providing health insurance coverage for the nation's aged and, more recently, the disabled. The National Council of Senior Citizens was founded during the early fight for this national health security plan for the aged. Over the years, we have watched Medicare grow and evolve to the program it is today.

While many of the program changes which have occurred over the years have improved Medicare, it is by no means without flaws. Coverage is incomplete, especially on the Part B, Supplementary Medical Insurance side. The aged and disabled pay large proportions of their incomes for medical care in spite of having Medicare coverage. The program's mandated cost-sharing levels have risen dramatically.1/ The last few years of budget reductions have shifted additional costs to elderly and disabled Medicare patients.

In short, the cost of both medical care and Medicare protection have risen for the aged and disabled. With these facts in mind, I stress our message to you today as you hear testimony on the "Fair Medicare Appeals Act of 1985." The Medicare program provides for entitlement to Federal health insurance which pays for medical services specified under the law. Payment for these covered services must be provided, and when it is denied, Medicare beneficiaries must have access to an appeals process which fairly and completely protects their rights. We believe that the current law governing Part B fails to assure this protection of beneficiaries' rights.

1/The hospitalized beneficiaries will have to pay a Part A deductible of $492 as of January 1, 1986, a 23 percent jump over the 1985 rate. The cost effectiveness of the new hospital prospective payment system is the primary cause of the accelerated deductible increase. The system is decreasing the length of the patients' hospital stays, but since the deductible is determined by dividing total costs over patient days, the deductible is rising at an accelerated rate.

We are asking Congress simply to amend the Medicare appeals process. We are asking that beneficiaries' access to an Administrative Law Judge and potential judicial review be included in Part B. That protection is now available under Part A. In addition, we are asking for the restoration of the beneficiary's right to be represented by his or her doctor or hospital in an appeals proceeding. That right was withdrawn by the Administration for reasons we believe were arbitrary and unjustifiable.

The National Council of Senior Citizens recognizes that the mounting Federal deficit severely restricts Congress' latitude to alter the program's benefits, regardless of the need for change. An improved appeals process is neither a benefit expansion nor a benefit change. It is a mechanism which should be available to assure access to Medicare benefits. We believe that it is not only reasonable and fair, but it is also the aged and disabled persons' right to ask for Congress' assurance that they not be denied the benefits to which they are entitled by law because their access to due process is unjustly restricted.

The assumption made twenty years ago that Part B claims would not be substantial enough to warrant access to court review is no longer valid. When Medicare was created twenty years ago, it was anticipated that costs under Part B, covering physician services and certain out-patient care, would remain relatively small compared to the Part A

Hospital Insurance covered services. This relationship currently exists, however, many changes over the years have markedly increased the cost of Part B services in real terms.

Inflation, technology, volume, and modifications in medical practice have all pushed up the cost of these services. Technology never dreamed of in the 1960s and services never provided outside of a hospital stay are now routinely rendered in doctors' offices or out-patient facilities. We have seen only the beginning of a major shift of costs from Part A to Part B as a result of hospital prospective payment.

For the Medicare patient, these changes mean higher costs, even with Medicare coverage. Out-of-pocket expenses and the excess fees patients must pay when physicians do not accept assignment are well-documented. While these costs are not the subject of today's hearing, we refer to them as integral parts of the Part B perspective we believe is needed when viewing the appeals process. As the costs of services rise, denial of payment represents an increasingly large financial loss to the patient and/or the provider. When the process which should serve as a vehicle to reverse an incorrect payment decision is anachronistic and denies people their rights, it should be changed.

The growing tragedy of the current Part B appeals system is the financial and emotional burden it needlessly places on the Medicare beneficiary. It is confusing and distressing enough to be notified that anticipated Medicare payment or payment already made is being denied. When beneficiaries discover that they have no recourse once a carrier's hearing officer renders an unfavorable decision, it can unnecessarily lead to despair. Take, for example, the case of a man in Texas.

Mr. Travis Flowers of Pollack, Texas, was hospitalized with a severe hip infection and a failed total hip replacement which ultimately required a surgical fusion and bone graft. He was placed in a total body spica cast which covered him from his abdomen to his toes. The plaster cast immobilized both of his hips and knees so that he could not sit, but only lie on his back. A bar fixed into the plaster between his legs separated his legs by approximately thirty-six inches, measured at the ankle. He was confined to bed for nine-and-one-half months.

After his discharge from the University of Texas Medical Branch in Galveston, Mr. Flowers required prolonged antibiotic therapy for his infection. The treatments were administered via an intravenous technique called a Hickman catheter inserted into his chest. The osteomyelitis clinic of the hospital in which Mr. Flowers was treated is one of only three in the country. The specialized treatments that he needed were unique to that institution.

Receiving this highly specialized antibiotic therapy required that Mr. Flowers be transported from home to the hospital a distance of 152 miles, one way. Since he was confined to bed, immobilized by the plaster body cast and at risk of bone graft failure if moved or jarred, he was carried to the hospital by ambulance. (His first experience with transportation to the hospital ended tragically. He was carried by van with the help of his wife and a friend. The trip apparently jarred loose the bone graft and Mr. Flowers had to undergo a second surgical procedure to correct the problem.)

A total of $4,015 in expenses for the ambulance trips was incurred between May and July of 1984. Mr. Flowers submitted the claims to Medicare which reimbursed him for a total of $1,510.68.

On March 26, 1985, Mr. Flowers received a letter from the Part B carrier in Dallas, Texas. The letter informed him that the ambulance services, for which he had already been reimbursed, should not have been covered because, the letter states, they were not "medically necessary." The letter went on to say, "You are required to refund the $1,510.68 with a check or money order within 30 days." He was informed that it should be made out to "Medicare Part B." He was even provided with an envelope for his convenience.

Mr. Flowers has followed the appeals process available to him under Part B. At the last step, a Fair Hearing requested by Mr. Flowers, the Hearing Officer, in a telephone hearing, concluded that Medicare "overpaid" for the ambulance services in the (corrected) amount of $1,511.68.

Mr. Flowers has reached the end of the appeals process available under current law. As he describes his situation: He is stuck with over $4,000 worth of ambulance bills. Medicare wants him to pay back the $1,511.68 which the program reimbursed him. He is afraid that Medicare will take back the "overpayment" through deductions from his monthly Social Security check.

Medicare continues to send Mr. Flowers letters about the money the program claims he owes the Federal government. He says he needs surgery on his knee to enable him to walk without crutches, but he says he is afraid to have it because he cannot be sure if Medicare will pay for it--or pay for it and then ask for him to pay the money back.

Under current Medicare law, Mr. Flowers cannot take his case to court. He has no further options under Part B appeals. If S. 1551 were law today, Mr. Flowers would not have to despair. He would be able to take his case to an Administrative Law Judge. If he were not satisfied with the ALJ's decision, he would have access to judicial review of his case. In short, Mr. Flowers would have access to due process which is his right. How can Congress justify that Medicare beneficiaries not have access to due process when they believe they have been denied benefits due them under the law?

The National Council of Senior Citizens strongly supports S. 1551 and urges swift adoption by the Senate. We can think of no argument sufficiently compelling to stop Congress from granting due process now denied the aged and disabled simply because their health insurance happens to be Medicare.

The witnesses appearing at today's hearing, the cases cited this morning, and the thousands of cases never heard provide sufficient evidence, we believe, that the system is unfair and needs correction. Yet these are not the only reasons we support the legislation. We believe that the Medicare Part B enrollees are at increasing risk of encountering problems similar to Mr. Flowers as costs reimbursable under Part B rise.

Two years ago Congress enacted a prospective payment system (PPS) under Part A Medicare. As this committee knows well, one of the goals of PPS is control over Part A outlay growth. As that goal is being reached, some of Part A costs are being shifted to Part B.

Elimination of unnecessary hospitalization and use of outpatient services for diagnosis and treatment when medically appropriate are objectives NCSC supports. However, we remind the Finance Committee, the Senate caretakers of the entire Medicare program, that changes in one part of Medicare can profoundly affect other parts of the program as well as its beneficiaries.

This is the case with PPS. As services are shifted from Part A to Part B, the aged and disabled are exposed not only to additional co-payments and the excessive fees of unassigned claims, they also lose access to due process. Therefore we urge this committee to push for enactment of S. 1551. By doing so, it will not only help the Mr. Flowers of the Medicare population, it will be taking a major step toward protecting those increasing numbers of elderly and disabled persons who will surely need access to due process as caseloads, claims filed, and program costs increase in the very near future.

Senator **Durenberger**. Thank you for your testimony.

Let me just say to all of the members of this panel that we particularly appreciate your coming here, if for no other reason than to offset at least the implication of the statement made by the administration. And Dr. Merson put it well when he said he had a hard time recognizing the part B policy that he bought, as articulated by Henry when he got up here to testify on behalf of the insurer who sold him the policy, and who annually renews that policy for him, and who extracts from him $15 and some cents per month in payment for that policy. And in exchange for that, we can say that we have expanded the benefits under that policy, and certainly that is true. I mean, we didn't talk about that 20 years ago. So, certainly there is a benefit. But also, there is an added expense on the part of the beneficiaries. There is an added involvement on the part of the beneficiaries and the providers in the system, and on behalf of the cosponsors of this bill, I just want to say that we're all in this one together.

I am here to represent the insurer, I guess; I am on the board of directors. Henry is just the guy that sort of runs the system for us. But I am on the board, and you have the right to come here and tell us we ain't running it very well. And it is our job to suggest to you a better way to do it.

It looks to me, from the testimony here, that there is some consensus that a more appropriate appeals proceeding, particularly expanding the rights under the supplemental part B, is appropriate. And if I have fairly summarized your testimony, I don't have to ask you any more questions. I just express my gratitude to all of you for being here.

If we have specific questions, which we may, to elaborate on your testimonies, we will send them to you in writing to be included in the hearing record.

Thank you very much for being here today.

Our next panel consists of John Seward, the vice chairman for the Council on Legislation of the AMA; Paul Simmons, the president of the Health Industry Distributors Association; and Dr. Irwin Lehrhoff, president of the National Association of Rehabilitation Agencies, on behalf of the American Physical Therapy Association and the American Speech-Language-Hearing Association.

I will say to the three of you that your statements will be made a part of the record, that you will score big points by summarizing them in fewer than 5 minutes, and we will commence with John Seward.

STATEMENT OF P. JOHN SEWARD, M.D., VICE CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, ROCKFORD, IL, ACCOMPANIED BY HARRY PETERSON, DIRECTOR OF THE ASSOCIATION'S DIVISION OF LEGISLATIVE ACTIVITIES

Dr. **Seward**. Thank you, Mr. Chairman.

My name is John Seward. I am a physician in family practice in Rockford, IL, and I am vice chairman of the American Medical Association's Council on Legislation. Accompanying me is Mr. Harry

Peterson, director of the association's division of legislative activities.

We are pleased to be here to testify on the issue of beneficiary and provider appeals under Medicare, and to support changes in the existing law to protect the rights of Medicare beneficiaries in dealing with supplemental insurance claims under part B of Medicare.

This hearing provides an opportunity to highlight one of the glaring inequities of the Medicare Program that unfortunately has been allowed to continue unchanged since the inception of the program.

While the Medicare law, as originally enacted and later as amended, has always authorized administrative appeals from determinations made under the hospital insurance portion of the Medicare Program, part A, such appeals have never been allowed for disputes arising out of part B. This longstanding inequity begs an immediate remedy. Medicare beneficiaries deserve no less.

The elderly, with just claims, should be allowed the right to present cases through the administrative process, and then if necessary to the courts, regardless of the length of docket. We, however, can not accede to any view that the elderly would knowingly present claims unless they felt just cause existed. Medicare should not be insulated from accountability for its errors and wrongful actions.

As there is no current authority under law to appeal the denial of benefits for part B beyond the carrier hearing, beneficiaries and physicians who have accepted assignment have virtually no recourse when coverage is denied. Your bill, Mr. Chairman, Senate bill 1551, would correct this situation by extending appellate rights to individuals denied benefits and by allowing provider representation of beneficiaries.

However, we believe that this bill could be improved by clarifying, in a manner similar to the House legislation, that the phrase "provider which furnished the services" includes the physician. Physicians are often in the best position to explain and justify charges made for services to beneficiaries.

Senator **Durenberger**. "It should be always."

Dr. **Seward**. Thank you.

Mr. Chairman, authorizing part B appeals will result in substantial gain for beneficiaries who have no recourse in situations where the carrier underpays the physician and other part B services.

We believe that the recent GAO report highlights and supports our view that there is a substantial injustice in the Medicare law due to the failure to allow full appeal process where an individual's rights are violated. The failure of Medicare law to allow individuals to appeal part B determinations is a glaring gap in the program that calls for immediate correction.

Over the years, the AMA has advocated adoption of legislation remedying this situation. Your bill, Mr. Chairman, clarified as I have discussed, would correct a substantial inequity in the law. We strongly support Senate bill 1551 and its prompt passage.

Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you very much. Paul.

[Dr. Seward's written testimony follows:]

Statement of the American Medical Association

to the

Health Subcommittee
Committee on Finance
United States Senate

Presented by

P. John Seward, M.D.

RE: Beneficiary and Provider Appeals Under Medicare

November 1, 1985

American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

Department of Federal Legislation
Division of Legislative Activities
(312) 751-6741

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Health Subcommittee
Committee on Finance
United States Senate

Presented by

P. John Seward, M.D.

RE: Beneficiary and Provider Appeals Under Medicare

November 1, 1985

Mr. Chairman and Members of the Committee:

My name is John Seward, M.D. I am a physician in the practice of family practice in Rockford, Illinois, and I am the Vice-Chairman of the American Medical Association's Council on Legislation. Accompanying me is Harry Peterson, Director of the Association's Division of Legislative Activities. We are pleased to be here today to testify on the issue of beneficiary and provider appeals under Medicare and to support changes in existing law to protect the rights of Medicare beneficiaries in dealing with Supplemental Insurance claims or Part B of Medicare.

This hearing provides an opportunity to highlight one of the glaring inequities in the Medicare program that unfortunately has been allowed to continue unchanged since the inception of the program. While the Medicare law, as originally enacted and later as amended, has always authorized administrative appeals from determinations made under the hospital insurance portion of the Medicare program (Part A), such appeals have never been allowed for disputes arising out of the Part B supplemental insurance program. This long-standing inequity begs an immediate remedy; Medicare beneficiaries deserve no less. Legislation introduced in the Senate by Senators Durenberger, Heinz and Chafee, S. 1551, would authorize administrative appeals and judicial review for issues arising under Part B of Medicare. The House reconciliation bill, H.R. 3290, also contains Part B appeals language. The American Medical Association strongly supports these proposals to authorize Part B appeals and urges prompt adoption.

The original rationale in the Medicare Act for not incorporating such appeal rights for the Part B portion of the program — such appeals would involve relatively insubstantial amounts and would clog the courts — is not, in our opinion, valid as justification in fact. Even if that rationale had some validity, denial of appeal rights improperly limits due process. Also, with the trend toward more outpatient care and inflation, Part B claims will become more substantial. The elderly with just claims should be allowed the right to present cases through the administrative process and then, if necessary, to the courts — regardless of the length of the docket. We, however, cannot accede to any view that the elderly would knowingly present claims unless they felt just cause existed.

As there is no current authority under law to appeal a denial of benefits for Part B services beyond the carrier hearing, beneficiaries and physicians who have accepted assignment have virtually no recourse where coverage is denied. S. 1551 would correct this situation by extending appellate rights to individuals denied benefits and by allowing provider representation of beneficiaries. However, we believe that this bill could be improved by clarifying (in a manner similar to H.R. 3290) that the phrase "provider which furnished the services" includes physicians. Physicians are often in the best position to explain and justify charges made for services to beneficiaries.

The AMA also supports the provision in S. 1551 to authorize aggregating of claims along with the establishment of the $500 minimum for an administrative hearing and $1000 minimum for judicial review. The ability to aggregate claims should reduce any concern about a backlog of small claims.

Mr. Chairman, authorizing Part B appeals will result in a substantial gain for beneficiaries who have no recourse in situations where the carriers underpay for physician and other Part B services. A June 28, 1985 report of the General Accounting Office (GAO) on the Medicare Part B beneficiary appeals process (GAO/HRD-85-79) found that there is a "high risk of underpayment in beneficiary submitted claims with large reasonable charge reductions and that carrier safeguards were ineffective in preventing these underpayments." In repeating this finding based on 1980 and 1981 GAO reports, the 1985 report goes on to point out that the underpayments have resulted in beneficiaries not receiving "the benefits they are entitled to by law." The report goes on to state:

> Because of the widespread concerns about rising Medicare costs, we can understand HCFA's emphasis on identifying and reducing unwarranted programming expenditures. However, HCFA has an equally important obligation of paying for services that are covered in order

> to protect the elderly and disabled from inequitable out-of-pocket expenses. This is especially true in light of the fact that (1) the percentage of claims submitted by beneficiaries is relatively high, (2) beneficiary liability for Medicare reasonable charge reductions is approaching $3 billion, and (3) the problems of the Part B appeals process discussed in the first part of this report have not been fully resolved with the courts.

We believe that this GAO report highlights and supports our view that there is a substantial injustice in the Medicare law due to the failure to allow full appeal process when an individual's rights are violated.

Mr. Chairman, the Congress should not continue to allow Medicare to be unaccountable to the over 30 million beneficiaries and their providers of health care services who may stand to be denied appropriate appeal procedure when their rights under the law have been violated. Individuals and their representatives should be allowed full recourse through the administrative process and then the judiciary when they believe that the Medicare program through an intermediary, carrier, or even PRO action or inaction has resulted in a denial of their benefits.

The failure of the Medicare law to allow individuals to appeal Part B determinations is a glaring gap in the program that calls for immediate correction. Over the years, the AMA has advocated adoption of legislation remedying this situation and has developed draft legislation to accomplish this result. Your bill, Mr. Chairman, if clarified as I have discussed, would correct a substantial inequity in the law. We strongly support S. 1551 and its prompt passage.

2206p

STATEMENT OF PAUL B. SIMMONS, PRESIDENT, HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION, WASHINGTON, DC

Mr. SIMMONS. Thank you, Senator.

Let me depart from my prepared testimony, which is long and probably boring, and just make a couple of points.

Senator DURENBERGER. Well, it was long. [Laughter.]

Mr. SIMMONS. And make a couple of direct points in reply to the administration. I can give you a sort of quasi-administration point of view, if there is any such possible; I am only 4 months out of this administration.

I spent 2 years as Dr. Desmarais' counterpart at the Social Security Administration, and I know a little something about how hard it is to spell out the appeal rights to millions of people. We had 36 million people on our rolls, many of whom are aged, many of whom are infirm, and in the case of Medicare beneficiaries, many of whom are actually quite ill.

Dr. Merson, who spoke a few minutes ago, is exactly right: 99 percent of the beneficiaries of these programs have real problems in knowing their rights. And in the case of part B, they have the extra problem of not being able to understand why they have no real rights at all.

These are people who, in many cases, have gone through a depression. They fought one or more wars for us, they fought wars to ensure the American way of life and jurisprudence, and when they come up against a system that directly touches their lives, directly touches the quality of care they receive and the lives that they live, and they don't have any rights, it is confusing.

A second point: Much has been made by Dr. Desmarais and other opponents of this bill that only about 3 million of the 225 million claims against the system each year are appealed to any real extent. I submit that this small number is a function not of the adequacy of the system that we are talking about here but the sure knowledge of the people—providers and patients—that most claims will be futile, that you won't have any more luck against this system than you would going down to D.C. Traffic Court and trying to get the boot off your car without paying a check for it. I thought that would go over well in this crowd. [Laughter.]

The third point I would like to make is that I don't think it is a correct assumption, by any means, that the chief concern over this part B process comes from the providers of services or the providers of goods, as I represent, and not the beneficiaries. Beneficiaries are really pawns in the system. If you look at the percentage of appeals in programs that do have a good appeals process, then I think you will see a much different picture, and I think you would see a much different picture here if there were a good appeals process.

It is not that the carriers haven't done a good job by and large with the system as it is, but I think the system as it is is not the system that we need today. And as you have pointed out, Senator, the world has changed in 20 years since this program began, and we can't afford to run a system that allows the executive branch to turn over a judicial function to the private sector without the judicial branch looking over their shoulder to see what they are up to.

Thank you very much.

Senator DURENBERGER. All right.

Dr. Lehrhoff.

[Mr. Simmons' written testimony follows:]

HIDA HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

PAUL B. SIMMONS
President

1701 PENNSYLVANIA AVENUE, N.W., SUITE 470, WASHINGTON, DC 20006 202/659-0050

STATEMENT BY PAUL B. SIMMONS
PRESIDENT
HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION
BEFORE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE, UNITED STATES SENATE
NOVEMBER 1, 1985

I am Paul B. Simmons, President of the Health Industry Distributors Association, which represents nearly 1,000 firms and their branches who distribute health and medical care products to the Nation's hospitals, physician offices and home health care providers. In many cases, our members are direct home health care providers themselves.

As you might expect, we agree with the preponderance of the testimony you will be hearing today from almost every actor on the health care stage who is affected, directly or indirectly, by the policy problem at issue in this hearing. And it is a serious problem.

Indeed, I suggest that the problem with the Part B Medicare reimbursement appeals process -- the central issue in this hearing and in the Bill, S. 1551, under consideration by this Subcommittee -- is one of the single-most uniting issues for all of the patient and provider community in this time of revolutionary upheaval in our Nations' health care system.

We applaud the Subcommittee's decision to hear the pros and cons of this most pressing issue. We appreciate the Subcommittee's willingness to hear us out. I believe we have much to say that will be highly relevant to your consideration of this Bill.

Much of my testimony will offer details on many of the concerns of the industry I represent. To save you time this morning, I request that my entire testimony be entered in the record. I will attempt to summarize some of our most pressing concerns in my oral remarks.

Simply put, we strongly object to the two-decade-long statutory denial of the rights of our industry and the people -- the patients -- we serve to the full and fair hearing of their disputes with the Medicare program that your Bill would ensure.

More than 175,000,000 times a year, providers and patients approach the Medicare Part B claims process with demands for reimbursement that may or may not be valid. But such claims will surely not be tested against a valid evaluation process under present law. And that issue is at the heart of the Bill your Subcommittee is considering today.

In no other government program in my experience does a claimant with a problem run into the kind of stone wall he or she will confront in pressing a Part B Medicare claim problem.

In no other large Federal program has the Congress so effectively removed access of claimants to the Federal courts -- in effect excluding the Judicial Branch from overseeing what the Executive Branch is doing out there in a marketplace which directly affects more than 30 million individuals.

And in no other large Federal program has the Executive Branch delegated more of its major policy decision-making powers -- in this case, powers that touch people's lives and the quality of medical and health care they receive -- to the private sector.

All of this is in direct consequence of Congress' decision 20 years ago to prohibit judicial review of Medicare Part B claims problems -- a decision that might have made sense in the start-up years of this massive program, but which makes no sense today in these years of massive upheavals in the way this Nation does health care business.

To put it simply: there's something grossly wrong with a system that makes the private sector -- the 50-odd Medicare Part B carriers -- the ultimate judge and jury in decisions that can materially determine the validity and appropriateness of the 175,000,000 claims that arise each year from cases involving our mothers and fathers.

The hallmark of our Constitutional system -- the hallmark of any humane government -- must be an adequate system of checks and balances that ensures that no branch of government, legislative, executive or judicial, can make policy and touch people's lives without the other two branches looking over its shoulder. In this case, the ultimate effect of Congress' decision twenty years ago is that our judicial system is effectively prevented from looking over a shoulder at policies that can touch the lives of nearly one in six of our population. That just plain doesn't make sense. The Medicare program is surely unique among all Federal programs in that rather than operating under a reasonable system of checks and balances, it operates under a non-system of non-recourse in which due process is unduly concentrated, not even in a branch of the National government, but in an agent of that government.

I need not remind Members of this Committee that the single overwhelming public issue in the last ten years over the financing crisis in the Social Security system was not whether the checks would go out next month, but whether the system itself was sound -- and would stay sound.

Here we have the most pervasive of all government programs in our society -- Social Security and Medicare -- which not only directly impact on the quality of life of 36 million retired and disabled persons, but which also directly affect the anticipated quality of life of the 120 million American taxpayers who are footing the bill for these programs right now. They, too, have to have confidence in the system. They, too, have to have reason to believe that the system will be there when they get there -- and that the system will deliver what's due them.

You can't have that kind of confidence as a present day taxpaper and future -- you hope -- beneficiary when you see your mother or father or grandmother become a de facto prisoner in a proceeding where an issue of public policy -- which is what a decision on a Part B claim really is, after all -- is decided by a non-government functionary whose word becomes law, simply because there's no chance to appeal to a public authority.

This is not to say that the carriers, by and large, haven't done as good a job as might be expected under such a system. But it is to say that this is the wrong system at the wrong time in the history of this program.

It's no system of justice when the nuances of public policy can be ultimately decided outside the proper forums of public policy debate.

It's no system when more than 50 individual entities -- the Medicare carriers -- are relatively free to generate their own individual brands of justice under the laws and rules that govern this program. Patients and providers can't go shopping for the "right" carrier any more than they can go shopping for the right place to get care or to do business. They need to know that if their problem is big enough, they can appeal to a power strong enough and high enough to ensure that national Medicare policy is applied uniformly throughout the land.

That power lies only in the courts until and unless the Congress acts to change its own interpretation of its own intent. Period.

And that's exactly the issue we're all here to talk about today.

I'll close with a couple of concrete kinds of cases where the system we have comes nowhere close to the system we should have -- the system we do have in almost every other major social program in this Nation.

The bill before this committee doesn't call for anything radical in the way of a change in the way we do the public's business. It calls for the right change in a process that long ago outlived its usefulness and relevance.

It doesn't seek revolution. It seeks only relevance to the real world we live in today.

And it doesn't portend -- if passed -- a big time caseload in the Federal courts. It seeks real time relief for the patient and provider community.

SOME SPECIFICS

At present, both beneficiaries and suppliers lack any means of redress when a claim is wrongfully denied or the reimbursement level is wrongly determined. That is problem number one. But, in addition, the absence of judicial review under Medicare Part B leaves the supplier community without any effective means of appeal over basic HCFA decisions on reimbursement policy.

Let me give just two examples. Recently, HCFA has decided that claims for seat lift chairs are being approved too easily by carriers and that the reimbursement levels are excessive. HCFA has directed carriers to tighten up on the approval process and to limit reimbursement to the lowest level at which any seat lift chair is available in the locality.

Of course, Medicare law calls for reimbursement at the 75th percentile of submitted charges. HCFA has the authority to move to a 25th percentile reimbursement ("lowest charge level") where it determines there is no significant difference among equipment available. But HCFA must propose this determination in the Federal Register and receive public comment before adding a new item to the list of equipment reimbursed at the 25th percentile lowest charge level.

In this case, HCFA has published no such a notice. Further, in setting a revised allowance for seat lift chairs, many carriers have taken a catalog price that makes no allowance for delivery or set-up, which most suppliers ordinarily provide to home-bound patients. Not surprisingly, this catalog price is from a firm that does not take assignment. It is lower than the 25th percentile in most areas. The actions being taken by the carriers, in response to these HCFA directives, clearly differ from the reimbursement procedures which Congress set. Nonetheless, lacking any way to appeal the individual reimbursement decision, suppliers and beneficiaries are equally bereft of any means of appealing the basic HCFA policy decision on these products. The providers, affected initially, have in many cases stopped taking assignment on seat lift chairs, and the beneficiaries are now the losers.

A second example will already be familiar to you. As you know, the Finance Committee, in developing the budget reconciliation for FY '86, voted to limit increases in rental rates for durable medical equipment to one percent this year. For future years, increases for both rental and purchased equipment are linked to the CPI. Nothing is said in the bill about reimbursement levels for equipment that is purchased in this current fiscal year.

Our understanding, confirmed by discussion with members of your Committee staff, is that it is the intent of the Senate that the prices for purchased DME should be recalculated for FY '86 under the usual statutory procedures.

However, even while Congressional action was pending, HCFA froze reimbursement levels for both rental and purchased equipment at the FY '85 levels. Moreover, in private discussions, HCFA officals have told us that they interpret the silence on FY '86 levels for purchased equipment in the bills now pending in the Senate and House to mean they can set whatever reimbursement levels they like for this equipment for FY '86. In their opinion, HCFA has the right to ignore the existing statutory requirement to recalculate charges annually according to the submitted charges of the previous fee screen year.

To say the least, this is an unusual assumption of authority. Very clear language in your Committee report and the eventual Conference report may solve this problem. Incredibly, we cannot even be certain that HCFA will pay attention to the report language. We hope so, but we cannot be sure. The risk remains that they will ignore the clear intent of Congress.

Obviously, if judical appeal for Part B decisions existed, this problem would not exist. HCFA would re-read the statute and the problem would be solved, without the necessity of lawsuit. It is only the absence of judicial appeal which has created this problem.

STATEMENT OF IRWIN LEHRHOFF, PH.D., PRESIDENT, NATIONAL ASSOCIATION OF REHABILITATION AGENCIES, LOS ANGELES, CA, ON BEHALF OF SUCH ASSOCIATION, AND ON BEHALF OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION AND THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION, ACCOMPANIED BY GEORGE OLSEN, LAW FIRM OF WILLIAMS & JENSEN, LEGAL COUNSEL TO NARA AND APTA

Dr. **LEHRHOFF**. Mr. Chairman, my name is Irwin Lehrhoff. Accompanying me is George Olsen of the law firm of Williams & Jensen, legal counsel to NARA and APTA.

I appear before you today to present the views of my organization and those of the American Physical Therapy Association and the American Speech-Language-Hearing Association.

The American Speech-Language-Hearing Association represents over 45,000 speech language pathologists and audiologists, while the American Physical Therapy Association membership is comprised of nearly 40,000 licensed physical therapists and physical therapist assistants nationwide. The National Association of Rehabilitation Agencies represents nearly 200 rehabilitation agencies, which furnish a variety of rehabilitative services to 3,000 nursing homes of approximately 300,000 Medicare beneficiaries. These members are primarily small businessmen or small businesses providing needed services to the Nation's elderly and disabled. It is the belief of these associations and their members that drastic reforms are needed of the Medicare beneficiary and provider appeals provisions.

Since most of our experience is with the appeals process under part B, I will confine my remarks to those problems. The points we have to make are simple:

First, the current appeals process under part B is not a fair process.

Second, the historical rationale for cursory review no longer is valid.

And third, the abusive situation which exists today should be corrected legislatively by providing adequate procedural safeguards.

The present appeals process provides unbridled discretion to the fiscal intermediary. There is no redress provided for program inefficiencies or arbitrariness of the intermediary or carrier. It may be 6 months or more before a hearing is even scheduled, because no time limits are imposed The hearing officer is appointed by the intermediary with no subsequent review either by an administrative law judge or a court. An impartial forum is needed because of the real conflict of interest where the intermediary is supposed to control costs, on the one hand, and to provide a fair hearing on the other. A fair hearing is not assured in these circumstances.

Consider these reports from members: The hearing officer is often a former long-time employee of the intermediary, well-acquainted with the staff who made the initial denial. In some instances, when hearing officers have supported the beneficiary and have overruled the intermediary, they have not been seen again as hearing officers.

Members have encountered hearing officers or claims reviewers with a definite bias against rehabilitative services. Therapists have found guidelines drawn up by intermediaries for certain services to be unrealistic, onerous, and to result in inadequate treatment. This has deprived beneficiaries of needed care and discouraged therapists from treating Medicare patients.

My second point is that the increased dollar amounts of part B claims warrant greater procedural safeguards. The part B appeal was originally set up as a bare-bones review for the small claims.

In 1972, Congress had to provide for a minimum claim amount of $100 to trigger a hearing, because approximately 45 percent of the hearings involved less than $100 and often a $5 or $10 claim. The size of the claims are now substantially higher.

The absence of a full and fair hearing is even more pernicious when the Health Care Financing Administration or its carriers use a statistical sampling procedure to project a recoupment demand for alleged overpayments. In these cases, a very small sample of Medicare claims will be actually reviewed by these carriers. In this way, a very small overpayment can be translated into an enormous recoupment demand.

Higher claims, are due to the advent of the prospective payment system for reimbursement of part A claims, which encourages a shift to medical treatment reimbursable under part B. Patients are discharged earlier, in need of more acute and sophisticated care and requiring more therapeutic support on an outpatient basis since they have a longer road to recovery. This means higher part B claims and more at stake for elderly patients when such claims are denied.

The size of part B claims clearly warrants an impartial and fair review, rather than the cursory review now in place.

We applaud the efforts of the Committee to examine the Medicare appeals process and to assure that the Nation's elderly receive a full and fair hearing on the benefits to which they are entitled.

Senator **Durenberger**. Dr. Lehrhoff, thank you.

[Dr. Lehrhoff's written testimony follows:]

SUMMARY OF TESTIMONY
OF DR. IRWIN LEHRHOFF
BEFORE THE SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

November 1, 1985

- Statement by Dr. Irwin Lehrhoff, President of the National Association of Rehabilitation Agencies, on behalf of such organization, as well as the American Physical Therapy Association and the American Speech-Language-Hearing Association. Members of these associations are respectively rehabilitation agencies, licensed physical therapists and physical therapists' assistants, and speech-language pathologists and audiologists.
- These associations support reforms to the Medicare provider and beneficiary appeals process but are most concerned with the Part B Medicare appeals process with which the members are most familiar.
- The Part B "fair" hearing mandated by statute is not fair and provides inadequate procedural safeguards. Examples of members' experiences are given.
- There is an inherent conflict of interest in the dual function assigned to the fiscal intermediary or carrier to hold down costs while attempting to act as an impartial arbiter of disputed claims.
- The intermediary or carrier does not always function efficiently or fairly in its initial assessment of claims, which situation is exacerbated by the absence of a fair appeals process.

- The dollar amount of Medicare Part B claims has risen substantially, partially due to the shift from Part A procedures to Part B procedures in response to the prospective payment system, and therefore such claims and the interests of the providers and beneficiaries warrant the safeguards necessary to an impartial review.
- Beneficiaries and providers with claims under Part B of Medicare should be provided access to an administrative law judge and judicial review.

Senator **DURENBERGER**. Gentlemen, let me express my appreciation to the three of you for your testimony, and say to our last two witnesses that Chuck Grassley will be back here in about 5 or 6 minutes to finish off the hearing.

We all are going off to vote right now, so I thank the three of you for your testimony today, and if we have more questions we will send them to you. Thank you very much.

[Whereupon, at 11:46 a.m., the hearing was recessed.]

AFTER RECESS

Senator **GRASSLEY**. At the request of Senator Durenberger, I am going to call the next panel in his absence.

Alan P. Spielman, executive director of the government relations, Blue Cross and Blue Shield Association here in Washington, DC; and Dr. Weeks, medical director of the West Virginia Medical Institute, on behalf of the American Medical Peer Review Association.

I would ask you, Mr. Spielman, to go first, and then Dr. Weeks. And then, at the conclusion of each of your testimony, if we have time I will pursue questions.

STATEMENT OF ALAN P. SPIELMAN, EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mr. **SPIELMAN**. Thank you, Mr. Chairman.

We appreciate this opportunity to comment on the Medicare appeals process. Under contracts with the Health Care Financing Administration, the Blue Cross and Blue Shield Association and member plans serve as Medicare intermediaries and carriers responsible for the day-to-day administration of the program.

We are strongly committed to ensuring that Medicare beneficiaries receive the benefits to which they are entitled, and that providers receive prompt payment for covered services without unnecessary burdens. Moreover, we fully support having a well-designed and administered process for handling claims disputes.

We recognize that, as Medicare increasingly becomes more complex, there is greater opportunity for misunderstanding and dis-

agreements in coverage and payment determinations. Therefore, we believe efforts to review the adequacy of the current Medicare appeals process are appropriate.

We have not, however, taken a position on S. 1551 or other proposals to alter the appeals process under Medicare. In reviewing this legislation, we believe the fundamental issue is balancing due process considerations with administrative considerations, and we hope that an understanding of certain key aspects of the current process and an identification of some policy issues will be helpful to the subcommittee.

Regarding the current process, our comments fall into three areas:

First, as indicated previously, intermediary and carrier reviews of claims denials are made by individuals not involved in making the initial determination. In our view, Medicare contractors do a good job in this area, given the constraints under which they must operate.

It is important to note that intermediary and carrier review decisions must be made in accordance with Medicare program instructions and other policy directives, as well as the law and regulations. Administrative law judges are bound only by the law and regulations. This situation, as well as the fact that beneficiaries may introduce new evidence at the appeals stage, means that reversals of contractor denials may well be due to factors other than mistakes in initial claims determinations.

Second, intermediaries and carriers process an enormous volume of claims for a program that is constantly undergoing complex changes. Their performance in making both initial and review determinations is monitored and evaluated by HCFA. As my testimony indicates, contractors are not under denial quotas.

Restrictions in funding for claims processing and other factors have reduced the ability of carriers and intermediaries to maintain timely claims processing, however.

I would also note that our activities relating to hearings and appeals, and beneficiary and provider inquiries, are also subject to severe funding restrictions.

Third, increased beneficiary and provider education and possibly claims processing changes have the potential to reduce some underpayments that lead to appeals. And while greater efforts in these areas are costly from an administrative standpoint, we believe that the money would be well spent.

Finally, we would like to suggest some issues for your consideration as you review the legislation:

It certainly is true that beneficiaries do not have the same avenues of appeal under part B of the program as they do under part A, and the legislation would address this. However, an expanded appeals mechanism would increase the number of appeals and their administrative costs.

In addition, an expanded appeals process should not be viewed as a substitute for sound policy interpretations of Medicare law and congressional intent. Indications that certain Medicare benefits are disproportionately subject to appeal may very well warrant a review of the policies on which the intermediaries and carriers base their determinations.

We would be pleased to assist the subcommittee as it explores this area.

Thank you.

Senator GRASSLEY. Thank you, Mr. Spielman.

[Mr. Spielman's written testimony follows:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

MEDICARE APPEALS PROVISIONS

BEFORE THE SENATE FINANCE
SUBCOMMITTEE ON HEALTH

ALAN P. SPIELMAN
EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS

NOVEMBER 1, 1985

Mr. Chairman and Members of the Subcommittee, I am Alan P. Spielman, Executive Director of Government Relations for the Blue Cross and Blue Shield Association, the coordinating organization for the nation's Blue Cross and Blue Shield Plans. Today, our Plans underwrite or administer health care coverage for 100 million Americans, including more than 20 million Medicare beneficiaries. Under contracts with the Health Care Financing Administration, our Association and member Plans serve as Medicare intermediaries and carriers responsible for the day-to-day administration of this important program.

We appreciate this opportunity to address Medicare appeals provisions and S. 1551, the Fair Medicare Appeals Act. As intermediaries and carriers, our responsibilities under the Medicare program include making timely and accurate coverage and payment determinations, pursuant to program instructions. To fulfill these responsibilities, it is necessary to deny claims for those items and services not covered by the program. We also administer certain aspects of the Part A and Part B appeals processes for denied claims. In addition, while not the focus of today's hearing, we also perform certain aspects of the appeals process for providers dissatisfied with Medicare reimbursement determinations.

We are strongly committed to assuring that Medicare beneficiaries receive the benefits to which they are entitled and that providers receive prompt payment for covered services without unnecessary financial or procedural burdens. In our private business, we try to make our adjudications as understandable as possible and provide avenues for subscribers to appeal claims denials within the framework of applicable law and rules. Also, in our private business we devote considerable efforts to assuring that providers understand the obligations of all parties under our contractual arrangements including the reimbursement, coverage policies, and billing procedures that apply when services are furnished to Blue Cross and Blue Shield subscribers. As intermediaries and carriers, our actions are taken in accordance with established program policies and administrative directives. However, we are well aware that in such capacity we take actions which reflect on our own image in the community. Our communications to beneficiaries regarding Medicare claims bear our own name, so any perception of non-responsiveness on initial claim determinations, reconsiderations, or fair hearings could undermine the good will of those we serve. For all these reasons, we fully support having an appropriately designed and well-administered process under Medicare to resolve disputes on claims.

We have not taken a position on S. 1551 or other current proposals to alter the appeals process under Medicare. However, in reviewing this legislation, we believe the fundamental issue is balancing due process considerations with administrative considerations. We believe a description of the current administrative process and a discussion of the policy issues involved may be useful in your deliberations.

Existing Appeals Process

After the intermediary or carrier makes an "initial determination" whether to pay or deny payment of a Medicare claim, an Explanation of Medicare Benefits (EOMB) or equivalent notice is sent to the beneficiary. In the case of Part A bills or assigned Part B claims, the provider also is notified. The EOMB explains the basis for payment or denial, and informs the beneficiary of the right to a review of this initial determination. Recently, the wording of the EOMB has been simplified to improve beneficiary understanding.

Under Part A, a beneficiary may appeal an intermediary's initial denial determination by requesting a "reconsideration". If the amount in question is over $100, an adverse reconsideration decision by the intermediary may be appealed at beneficiary request to an HHS/SSA administrative law judge (ALJ). The beneficiary may request a review of an adverse ALJ decision by the HHS Appeals Council, which may choose whether to review it. If the amount in question is at least $1,000, the beneficiary may appeal the ALJ's decision to a federal court, regardless of any decision by the Appeals Council. For initial denial determinations involving amounts of $100 or less, a new process is being implemented for a one-year trial period which permits beneficiaries to have an informal, non-adversarial hearing by the intermediary.

For Part B, a beneficiary may appeal an initial denial determination to the carrier (or the intermediary in the case of certain Part B claims such as outpatient hospital claims). If the amount in question is over $100, this review decision may be appealed at a hearing before a carrier fair hearing officer. If the amount is $100 or less, and the denial involved certain issues, such as the claimant's veracity, an informal hearing may be held by the carrier.

Under both Parts A and B, when a claim, initially denied as not being reasonable and medically necessary or as being custodial care is appealed, the review process includes a decision on whether to waive the liability for payment by the beneficiary and, if so, whether to waive the liability of the provider. In such cases, the parties to the review determination may seek a review of both the coverage and waiver of liability issues. Multiple claims of one or more beneficiaries involving a similar issue may not be aggregated to meet the dollar thresholds for various stages of the appeals process.

Under HCFA rules, a Part A intermediary's reconsideration must be made by an individual other than the one who made the initial determination. A Part B carrier hearing officer also must meet certain standards. The hearing officer must be an attorney or other individual with a thorough knowledge of Medicare law, rules and policy instructions. A hearing officer may not be the same person who made the initial determination on a bill or claim, and should disqualify himself from any hearing where a conflict of interest might exist. The hearing officer must state that he is acting on behalf of the government, and must safeguard the rights of all parties to the hearing.

It is important to note that HCFA requires that the review decisions of carrier hearing officers and intermediaries be based on Medicare program general instructions such as manuals and transmittals, as well as on the Medicare statute and regulations. Administrative law judges are bound only by the Medicare statute and regulations and not by Medicare program instructions that detail criteria and guidelines for making coverage decisions.

Medicare intermediaries and carriers process an enormous volume of bills and claims. In 1985, they handled almost 50 million Part A bills and nearly 260 million Part B claims. HCFA now estimates that this total volume will increase by 9% in 1986. Additionally, as the Committee well knows, the Medicare program has undergone numerous changes, many of which have added to the complexity of processing claims and to the challenges that beneficiaries and providers have in understanding this program. Intermediaries and carriers are evaluated annually on the accuracy of their claims and review determinations as part of a formal HCFA process known as the Contractor Performance Evaluation Program (CPEP).

The CPEP evaluation is used by HCFA to determine whether intermediaries and carriers meet current standards or need to improve their performance. Failure of these standards may be the basis for revocation or non-renewal of an intermediary or carrier contract to administer the program. In addition to the CPEP evaluation, intermediary reconsideration reviews and carrier fair hearing decisions are randomly sampled and reviewed by HCFA Regional Offices. Thus, our performance at all levels of the claim determination and hearing process is continuously monitored.

We would note that, pursuant to Section 2326 of the Deficit Reduction Act of 1984, the General Accounting Office is studying a number of issues relating to the selection, evaluation and reimbursement of Medicare contractors, including whether the CPEP standards are adequate and properly applied. Under S. 1730, the pending Medicare budget reconciliation legislation, the GAO study would be due in January 1986. We believe that this study may help identify any problems with respect to the process used to evaluate intermediary and carrier handling of claim determinations and fair hearings.

Current Issues

Recently, several concerns have been expressed about the current appeals process. As many have noted, a record number of Part B carrier review or reconsideration requests are pending. In addition, concerns have been raised that the dollar amounts of many Part B claims also have grown dramatically with the increased use of outpatient care and sophisticated medical techniques, thus exposing beneficiaries to substantial out-of-pocket liability. Another concern expressed by some providers is whether Part A intermediaries are arbitrarily denying Skilled Nursing Facility and Home Health Agency bills, supposedly in order to meet so-called "quotas" on cost-effectiveness of medical and utilization reviews. These providers have alleged further that intermediaries are not penalized for inaccurate denials.

S. 1551 would establish the right of a beneficiary to appeal to an administrative law judge for disputed Part B claims of $500 or more. The bill also would permit a provider to represent a beneficiary for purposes of appealing Part A decisions, and permit multiple claims to be aggregated for appeal purposes if they involve similar or related services for the same beneficiary or involve common issues of law and fact regarding services for several beneficiaries.

We are not certain why the number of review and reconsideration requests are at a record high. Increases in the average dollar amount of Part B claims may have resulted in beneficiaries' questioning denied claims that would not have been questioned a few years ago. The increase in the total number of claims, as the beneficiary population continues to grow and age, may also contribute to this situation.

Another factor may be the current limited carrier budgets for claims processing. The General Accounting Office recently reported to the Chairman of the Special Committee on Aging concerning the processing of Part B claims. GAO stated that an accurate carrier claims processing system is important because it can reduce the number of beneficiary underpayments and consequent appeals. The report also noted that GAO reports in 1980 and 1981 had identified ways to improve claims processing. We believe that increased beneficiary education about completing and filing claims and enhancements in claims processing systems could help correct some problems that result in beneficiary underpayments. However, these activities cost money and therefore, may not be accomplished due to severe restrictions in the administrative funds available for Medicare contractor functions.

Restrictions in funding for intermediary and carrier claims-processing have already resulted in serious problems. The ability of intermediaries and carriers to process bills and claims in a timely manner has been reduced as a result of funding restrictions, the need to implement a multiplicity of changes, and recent unexpected increases in claims volume. In addition, severely limited claims-processing budgets have precluded a number of improvements, such as computer system upgradings and enhanced beneficiary and provider education.

In regard to concerns about reduced access to skilled nursing and home health services due to alleged denial "quotas", we do not believe this to be true. There are many checks and balances in HCFA's review system that work to prevent such a situation. While intermediaries are evaluated by HCFA on the cost effectiveness of their MR and UR activities, they also are evaluated on the accuracy of their coverage determinations. Second, hearing and appeal costs, such as salaries of fair hearing officers and costs to prepare documentation of cases appealed to ALJs, must be paid out of limited intermediary and carrier budgets that are being squeezed. Third, HCFA program instructions require that the dollar amount of reversed denials must be subtracted from savings attributed to intermediary and carrier medical and utilization review responsibilities. This requirement removes any incentive to deny claims in order to increase savings reported to HCFA.

Further, where reversals do occur, they may well be due to reasons other than intermediary or carrier error. As noted previously, our hearing officers are bound by HCFA program instructions, while ALJs are not. Second, at a hearing before an ALJ, a claimant may introduce new material evidence that was not available when the initial determination was made. These administrative factors also may affect any expanded process for appeals.

Administrative and Policy Considerations for an Expanded Appeals Process

While administratively we believe that intermediaries and carriers do a good job at the review functions to which they have been assigned, the fact remains that as Medicare increasingly becomes more complex, there is greater opportunity for misunderstanding and disagreements in interpretations of coverage and payment determinations. Also, it is true that the Part B appeals process does not afford the same levels and types of reviews as those afforded under Part A. We therefore believe that efforts to review the adequacy of the current process are appropriate. Under any conditions, but particularly now, we should all join to assure that there is reasonable protection from any arbitrary or uninformed denials.

However, an expanded appeals process, including aggregation of similar claims to meet dollar thresholds, an ALJ level of appeal under Part B and allowing Part A providers to appeal on behalf of beneficiaries, would increase the number of appeals and their associated administrative costs. In addition, as GAO has noted, the need to pursue appeals might be reduced through improved beneficiary education regarding coverage and claims submission, and possibly by changes in claims processing procedures.

Another policy consideration relates to the fact that decisions by ALJ's are not bound by administrative policy interpretations. As more and more claims decisions are made without reference to these interpretations, the issue becomes whether policy is being determined deliberatively by the legislative and executive structure, or on a case-by-case basis through appeals procedures. An expanded appeals mechanism should not be viewed as a substitute for the establishment of consistent, understandable policy interpretations of Medicare law and congressional intent.

Finally, if specific Medicare benefits are found to be disproportionately subject to review and appeal, this may indicate that a coverage or payment policy issue specific to the benefit in question also may need to be addressed. We would be glad to assist you in considering the causes of such situations.

Conclusion

In conclusion, whatever the appeals system in effect, Medicare intermediaries and carriers will continue to do the best job possible within prescribed fiscal and contractual conditions. In considering any expansion of the system, the fundamental issue is balancing due process concerns with administrative considerations and weighing the legislative and regulatory versus the judicial role in policy making. We would be glad to offer any assistance to you in regard to this important and complex area.

Dr. Weeks.

STATEMENT OF HARRY S. WEEKS, M.D., MEDICAL DIRECTOR OF THE WEST VIRGINIA MEDICAL INSTITUTE, ON BEHALF OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION

Dr. WEEKS. Senator Grassley, thank you for the opportunity to appear here today.

I am Dr. Harry Weeks, a practicing physician from Wheeling, WV, and medical director of the PRO in West Virginia. I am here today representing the American Medical Peer Review Association, which is the national association of PRO's. And I welcome this opportunity to express our concerns relevant to Senate bill 1551. And I think this can best be served if I am allowed to submit my entire written testimony to the record, with your permission.

I would simply like to highlight two or three items in our executive summary and stand by if you have any questions to ask me, since I am about the sole representative of a real PRO here today.

AMPRA is supportive of the right of Medicare beneficiaries and participating providers and practitioners to fair and responsible appeal process, and we believe that the proposed changes in S. 1551 will strengthen the rights of the beneficiaries; however, we have one suggested modification: We are concerned with the precedent being established that would permit both practitioners and providers to represent beneficiaries in the appeal process. AMPRA believes that only the attending physician, that individual most responsible for the care provided, should be allowed to represent beneficiaries in a formal appeal.

This modification would discourage appeals on the account of the institutional provider's financial interest and reduce the potential for conflict of interest.

We would strongly recommend that an intensive campaign be established by the Social Administration, HCFA, the health care industry, et cetera, to educate Medicare beneficiaries as to their rights under the existing system.

I recently had an opportunity to participate in a symposium sponsored by AARP, in which they are training their advocates to advise people on their rights, and I found it to be quite stimulating. They have done a real professional job, and they have come out with an information set that certainly the members that were at this hearing today could benefit if they saw it.

But I think more of this needs to be done, because communicating with the elderly, as I see it, is really what the beneficiaries need. And this was brought home to me in April of this year when, through the grapevine from my home town, I heard that an Italian lady who was in our neighborhood when I grew up was looking for me. I picked up the phone and called her, and it turned out that we hadn't spoken to each other for almost 50 years, and she wanted to talk to me about the activity of the PRO and so on and so forth, and I said, "Well, what is the problem, Mrs. DeLapa?" And she said, "Well, do I owe the hospital any money?" And I said, "Did you get a letter?" She said Yes, and I said, "Well, we have about 20 form letters; can you tell me the numbers in the right hand corner on the upper side?" And she said, "Well, that's the whole problem, Harry; I'm blind now, and I can't read whatever you sent me. My daughter just said that you sent me a letter," which happened to be a copy of the denial.

I think that this tells a story, in that, irrespective of what we think we have done in the way of proper steps to educate the beneficiaries, there is always room for that extra step and a need for some clarification and strengthening. And we would recommend this is one thing that needs to be done.

I have found personally that, reading most of the leaflets that come out, that they are pretty dull and dreary, and you don't really remember what they say. So, I think we need to redouble our efforts in education.

Thank you.

Senator Grassley. Thank you, Dr. Weeks.

[Dr. Weeks' written testimony follows:]

STATEMENT OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION (AMPRA)
BEFORE THE SENATE FINANCE COMMITTEE'S
SUBCOMMITTEE ON HEALTH
REGARDING MEDICARE APPEALS

S
Presented by: Harry W. Weeks, [redacted]., M.D.
Medical Director, West Virginia Medical Institute

November 1, 1985

Mr. Chairman, I am Harry Weeks, M.D., a practicing physician from Wheeling, West Virginia and the Medical Director of the West Virginia Medical Institute, the PRO for West Virginia. I come before you today representing the American Medical Peer Review Association (AMPRA). AMPRA is the national association of physician-based medical review entities and the Peer Review Organizations (PROs) under contract to Medicare. I welcome this opportunity to express AMPRA's views concerning S. 1551, the Fair Medicare Appeals Act, and to share our experiences with the appeals process under the PRO program.

Let me say at the outset that we strongly support the right of Medicare beneficiaries and participating providers and practitioners to have a fair and responsive appeals process. The Medicare statute sets forth specific requirements designed to assure due process with regard to decisions rendered by the program and its agents. In the PRO program and during the PSRO era, we have participated in the appeals process, and we believe, for the most part, that it has worked well.

Medicare and the Appeals Process

We believe that it is important to distinguish between the appeals process outlined under Section 1869 of Title XVIII and the reconsiderations and appeals authorized by Section 1155 of the Act. In the case of Section 1869, beneficiaries may request a reconsideration of decisions made by Medicare contractors (i.e. fiscal intermediaries or carriers) if the matter involves: 1) entitlement to benefits under Part A or Part B; or, 2) the amount of benefits payable under Part A or Part B. In the case of entitlement disputes, beneficiaries may pursue appeals through the Social Security Administration and, ultimately, in the federal courts.

In the case of disputes over payment amounts, the statutory provisions governing appeals are different for Part A and Part B. Part A payment disputes are first reviewed by the Health Care Financing Administration (HCFA). If the dollar amount is greater than $100, the beneficiary has the right to a hearing by an administrative law judge and a further hearing by the Social Security Appeals Council. If the amount in controversy exceeds $1,000, the beneficiary has the right of judicial review of the final administrative ruling.

Part B payment disputes may first be reconsidered by the Medicare carrier, and, if the amount in dispute exceeds $100, the beneficiary may request a hearing by a representative of that carrier. There is no further administrative appeal or judicial review of these final carrier decisions.

Under separate provisions of the Medicare statute, there are additional provisions dealing with the appeal of disputes arising from the application of the waiver of liability (Section 1879), with appeals by providers of Part A services (i.e. the Provider Reimbursement Review Board - Section 1878), and with appeals of PRO decisions (Section 1155). We want to discuss in more detail our experiences with provisions of Section 1155 and our recommendations concerning this appeals process.

Reconsiderations and Appeals of PRO Decisions

Under Section 1155, a Medicare beneficiary, a provider, or an attending physician who is dissatisfied with a PRO initial denial determination is entitled to a reconsideration by the PRO. The reconsideration is performed by an individual with appropriate medical credentials and one not involved in the initial determination. It should also be noted that PROs are required, prior to issuing a denial notice, to provide the institution and the attending physician an opportunity to discuss the circumstances that have led to an intention to deny payment for a Medicare case. Thus, providers are given an opportunity to offer additional insight or data on a particular case prior to an initial denial decision, and influence the final PRO determination.

If a Medicare beneficiary is dissatisfied with the results of a reconsideration, then an appeal to an administrative law judge is allowed if the amount in controversy exceeds $200. Judicial review of such administrative decisions is provided if the amount in dispute exceeds $2,000. It should be noted that an administrative or judicial appeal of a PRO reconsidered denial is limited to a beneficiary.

We have discussed these appeals procedures with our members and have gathered some data concerning the frequency of appeals and their disposition. Based on the limited information on hand, we have determined that approximately 30% of requests for reconsiderations result in reversals of the initial PRO determination. Thus, there is clear evidence of the willingness of PROs to consider new information and act accordingly.

AMPRA is also concerned that administrative law judges are not well-qualified to render medical decisions. We would oppose any effort to broaden the appeals procedure under Section 1155 to permit providers or practitioners to take PRO final decisions before an administrative tribunal. In many respects, this would represent a substitution of administrative law judges for the medical peer review program. We believe that Congress granted PROs authority for the very reason that PRO physicians are in a better position to render medical decisions than are administrative law judges.

While it is still early in the history of PRO operations, we believe there is not sufficient evidence to support changing the current process for appealing PRO decisions. Both patients and providers are given opportunities to present new evidence and to pursue appeals of all initial denial decisions. While providers may not pursue these appeals beyond reconsideration by the PRO, the beneficiary has additional recourse where the amount in dispute is significant. AMPRA does not support changing the existing reconsideration and appeals process under Section 1155.

S. 1551, The Fair Medicare Appeals Act

We have reviewed your bill, S. 1551, Mr. Chairman, and we are not opposed to the changes you propose to the appeals authorized under Section 1869. We would like, however, to make several comments about the bill based on our experience in the PRO program and suggest one modification.

First, we agree with your proposal to grant administrative and judicial review of contractor decisions on the same basis under Part A and Part B. It does not, in our view, make sense to maintain the differences that we described earlier between appeals under Part A and Part B. With regard to another change proposed in S. 1551 - the appointment of providers as beneficiary representatives - we want to express some cautionary views.

In considering possible appeals that arise under Section 1869, we believe that those disputes centering on payment amounts or coverage create a strong incentive for providers to pursue an appeal on behalf of a beneficiary particularly given the fact that a provider's financial interest is significantly greater than the beneficiary's. If, under these proposed changes to Section 1869, the volume of appeals increases dramatically as a result of providers representing beneficiaries in requests for an appeal, markedly increased cost and adminstrative burdens will fall on the administrative law judges and the courts. We do not believe this is your intention and, therefore, we would recommend maintaining the existing provision that appeals beyond the Medicare contractor level be pursued by beneficiaries only. Further, AMPRA would suggest modifying S. 1551 to permit only the attending physician - that individual most responsible for the provision of services to the beneficiary - to assist the beneficiary in the preparation of the appeal and act as the beneficiary's formal representative. What we want to discourage are appeals pursued on the account of the institutional provider's financial interests.

In summary, we would support S. 1551 with the appropriate modification suggested above. We believe the opportunities for appeal of payment or coverage decisions should be consistent under Part A and Part B.

Other Issues

In closing, we would like to share with you some concerns about the appeals process in general. You should be aware that PROs would like to shift the locus of their review activities from retrospective reviews to preadmission or preprocedure reviews. We are acutely aware of the difficulties arising from denials after the services have been provided and the costs which have been incurred. In the future, we expect more of our efforts to be focused on prospective review, and we believe this will result in fewer appeals and more effective compliance with program policies.

It is also AMPRA's observation that the changing Medicare system and the various rules and regulations that accompany the program underscores the critical need at this time for an intensified Medicare beneficiary education initiative. The Medicare appeals process is a perfect example of the growing complexity of the Medicare system that can only be overcome through a concerted and consistent educational effort spearheaded by the Social Security Administration, the Health Care Financing Administration (HCFA), and the health care industry. The need is more acute particularly now that hospitals have the right to issue notices of noncoverage that shifts financial liability from the Medicare program to the beneficiary.

Finally, AMPRA would like to bring to the attention of the Finance Committee an apparent inconsistency in the rules that hold beneficiaries harmless from PRO denial determinations. As you are aware, Mr. Chairman, hospitals are precluded from directly billing beneficiaries for hospital services rendered that PROs have denied. However, hospitals are not prevented, in the event of a PRO denial, from directly billing the beneficiary for any cost sharing requirements of the Medicare program, particularly the four hundred dollar first day deductible. AMPRA urges the Finance Committee to investigate this coverage policy issue in the coming year.

Senator **Grassley**. I will start with Mr. Spielman.

As you know, S. 1551 permits providers who furnish the services that are in question to represent beneficiaries in their appeals. We would like to know what sort of an impact you feel that that provision would have if enacted—that would be the general impact—and then, specifically how it would impact upon the work of Blue Cross/Blue Shield, or how it would impact generally upon that.

Mr. **Spielman**. With respect to the impact, I think I must indicate some uncertainty. We don't have any analysis that would give us a firm basis for predicting what the impact would be. I think one could argue or speculate that you would see an increased number of appeals, to the extent that beneficiaries are not now exercising a right in cases, as mentioned earlier today perhaps, where in fact they might not have any liability. To the extent that that results in an increase in appeals, Blue Cross and Blue Shield's Medicare intermediaries or carriers would obviously be faced with an additional workload. We have not done any dollar estimate or claims estimate on that point, though.

Senator **Grassley**. Do you believe that the recommendations made by the General Accounting Office—or, as we refer to it, GAO—in the past reports regarding ways to improve claims processing would be helpful? And if so, more specifically, have you attempted to implement any of those recommendations?

Mr. **Spielman**. On that particular point, I think the Administration might be able to respond more fully. I think each of those recommendations have to be looked at separately, and there has been some changes over the years since some of those studies have been made.

I think that the key question is providing an adequate level of funding for claims processing. And then, certainly, the claims processing experts can figure out the best specific techniques to improve that process.

So, I think I would argue that greater efforts in this area would be appropriate, but I couldn't say specifically which of those recommendations should be implemented. Many of them have been addressed through enhancements in the evaluation process that carriers and intermediaries go through. Certainly, more can be done, however.

Senator **Grassley**. So, there has been some attempt to implement some of the recommendations, you feel?

Mr. **Spielman**. Yes. There is a greater emphasis, for example, on claims payment errors in the evaluation process; although, I would point out that, to the extent the contractors have limited funds, many of them may fail those particular standards. So, you have to look at it two ways: both to address standards, plus to give the contractors an adequate amount of money to do it, recognizing that it must be done efficiently and effectively.

Senator **Grassley**. You have reiterated Blue Cross and Blue Shield's commitment to the proposition that people receive the benefits to which they are entitled. Are there any other modifications that you can suggest, aside from the provisions contained in S. 1551, which would help address the problem?

Mr. **Spielman**. Well, as my colleague mentioned, I think beneficiary education is key. As you know, the Medicare Program is constantly undergoing changes. Changes are pending right now. And it is very difficult for those to be communicated. They are complex by themselves, but it is difficult for them to be communicated out to the beneficiary population, and perhaps some greater efforts in those areas would help.

In addition, very limited efforts are placed on provider education under Medicare. There simply is not enough administrative money to go around.

So, I think those two areas in terms of education would help. And again, as I mentioned previously, greater emphasis on the key role of a good claims processing system, and systems for handling inquiries in hearings and appeals, would probably help.

Senator **Grassley**. Dr. Weeks, what is your impression of the reconsideration process currently in place under the Peer Review Organization Program? And more specifically, do hospitals have ample opportunity to present evidence and argue their case through the existing process?

Dr. **Weeks**. The process is working. It is a little premature, in my judgment, to even consider changes. The effect of the program is really just starting to take hold, and the word is spreading generally in the medical profession.

I think that the situation at least in my PRO is working. We had roughly 130,000 discharges. Out of those, we had 2,500 questioned cases, of which there were 1,200 denials, of which 304 were reversed—roughly 25 percent. So, at least we can demonstrate that there is flexibility and a willingness to listen to additional testimony.

As far as the hospital is concerned, either directly or indirectly they certainly have ample opportunity to get into the act. I say this in recognition that I am going to get caught in a crossfire. But the physicians currently are being manipulated severely by the hospitals. In general, this usually comes down, at least in our area, to about 10 percent of hospitals that are very sophisticated. And through the physician at least, they are getting their licks in at producing the testimony that comes before the reconsideration. So, I think they are given adequate opportunity to present their side.

In addition, we have set up an informal liaison committee with the representatives of the State hospital association to meet quarterly and try to resolve procedural disputes, and so forth. So, the doors are open.

Senator **Grassley**. All right. I think those are all of the questions that were asked.

Dr. **Weeks**. Thank you.

Senator **Grassley**. You might expect some to come in writing from members that can't be here.

I thank this specific panel, and I thank everybody who testified. I will adjourn the meeting at this point.

[Whereupon, at 12:16 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

DEC 10 1985

Edmund J. Mihalski, C.P.A.
Deputy Chief of Staff
for Health Policy
Committee on Finance
United States Senate
Attn: Ms. Shannon Salmon
Washington, D.C. 20510

Dear Mr. ~~Mihalski~~ Ed:

Enclosed are responses to the additional questions you forwarded to me following the November 1 hearing on Medicare appeals procedures. Please let me know if I can provide you with any additional information.

Sincerely yours,

Henry

Henry R. Desmarais, M.D.
Acting Deputy Administrator

Enclosures

Q from Packwood

Q. Why are the amounts that trigger an appeal for PROs higher than the minimum amounts of $100 and $1000 for the rest of part A?

A. When Medicare was originally enacted, part A appeal tolerances were set, in law at the $100/$1000 levels. The legislation enacting the Peer Review Organization program specified appeal tolerance levels of $200/$2000 for cases subject to PRO review. Since PROs currently review only inpatient hospital care, these tolerances are realistic, recognizing the high cost of such care.

Q. Do you think that all Medicare appeals amounts should be uniform? If yes, why? If no, why not?

A. Uniform appeal tolerances would simplify, to some extent, the administration of the appeals mechanism. The tolerance levels of $200/$2000 are certainly reasonable for inpatient hospital care. However, uniform tolerances at that level could disadvantage some beneficiaries receiving care from other providers such as home health agencies where the cost of services might not reach those levels.

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SENIOR COUNSEL
MOSS AND WILKINS

January 17, 1986

Ms. Shannon Salmon
U.S. Senate
Committee on Finance
Washington, D.C. 20510

Dear Shannon:

Attached is the response for Linda Billows for inclusion in the Finance Committee hearing record regarding Medicare appeals.

I apologize for the delay. Please feel free to contact me if you need further clarification.

Best regards,

Sincerely,

Dayle

Dayle Berke, Director
Government Affairs

REPRESENTING THE NATION'S HOME HEALTH AGENCIES, HOMEMAKER-HOME HEALTH AIDE ORGANIZATIONS AND HOSPICES.

HOMECARE

A "technical denial" is a form of coverage denial, created by HCFA policy makers, which is based on a determination by a fiscal intermediary (FI) that a home health visit failed to meet a statutory or regulatory requirement, other than medical necessity.

Examples of "technical denials" are those where the FI finds the client did not meet the homebound or "in need of intermittent skilled nursing care" eligibility requirements, despite the fact that the home health agency (HHA) has made a professional medical judgement that the patient has done so.

A specific example of such a technical denial was a recent case where a home care visit by a skilled nurse was denied because the elderly patient was not considered by the FI to be homebound. The patient left home once a month for physician office visits, requiring the assistance of two persons to transport her from house to car and left home for no other purpose.

According to HCFA, technical denials are not subject to payment under waiver of liability and are appealable only by the beneficiary. This results in great harm to both beneficiaries and HHAs. The Medicare beneficiary is harmed since the HHA which rendered care is barred by current HCFA policy from joining in or leading the appeal. Most Medicare patients, their families or survivors may lack either the understanding or the stamina to appeal a "technical denial" on their own. Medicare beneficiaries are also adversely affected because HHAs facing severe monetary losses from "technical denials" must avoid care of patients whose care might result in a "technical denial". HHAs will begin to limit the number of these patients, or cut back on needed visits, or simply not bill for visits that are made -- which no business can afford to do for long. The result is an inevitable narrowing of the Medicare home health statutory benefit.

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December 6, 1985

United States Senate
Committee on Finance
219 Dirksen Senate Office
Building
Attention: Ms. Shannon Salmon
Washington, D.C. 20510

Dear Ms. Salmon:

Please find enclosed the responses of Dr. Irwin Lehrhoff to the follow-up questions of Senator Packwood (also enclosed) with regard to Dr. Lehrhoff's testimony at the November 1, 1985, Subcommittee on Health hearing regarding Medicare appeals procedures.

Sincerely,

Ann S. Costello

Ann S. Costello

ASC/eak
Enclosures

Q from Packwood

Question for Dr. Lehrhoff

Dr. Lehrhoff, as you have mentioned, you are speaking on behalf of the National Association of Rehabilitation Agencies, the American Physical Therapy Association and the American Speech-Language-Hearing Associaton. How are the concerns of these organizations uniquely affected by the current appeals process?

How would their unique concerns be affected if S. 1551 were enacted?

The National Associaton of Rehabilitation Agencies, the American Physical Therapy Association and the American Speech-Language-Hearing Association are affected by the current Medicare appeals process because of the fact that many of the members of these three organizations are Medicare providers or suppliers. Due to this fact, the services provided or supplied by our members are among the targets of claims denials which form the basis for appeals.

One key problem for our members in the review process is the fact that most claims review departments are staffed by nurses who are not as familiar with the services provided by our members as they are with services rendered by physicians. For example, a claims reviewer who has no knowledge of speech language pathology cannot evaluate the rehabilitation needs of a stroke victim regarding communication and cognitive skills. This lack of familiarity leads to arbitrariness in decisions regarding claims submitted by our members, making the need for further review even more critical.

Our members stand ready and willing to represent Medicare beneficiaries in their appeals, yet the stance of the Health Care Financing Administration precludes this assistance from being accepted. This is especially problematic because it is these very providers and suppliers who could be most effective as the representatives of the beneficiaries in the appeals process. After all, the services denied coverage were rendered by these providers and suppliers.

If S. 1551 were enacted, these major inequities in the current appeals process would be eliminated.

AMERICAN COLLEGE OF GASTROENTEROLOGY
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STATEMENT OF

JOHN P. PAPP, M.D., F.A.C.G.

PRESIDENT
OF
THE AMERICAN COLLEGE OF GASTROENTEROLOGY

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

CONCERNING

ADMINISTRATIVE APPEALS
AND
JUDICIAL REVIEW OF MEDICARE CLAIMS

ON

NOVEMBER 1, 1985

Mr. Chairman, and members of the Subcommittee, the American College of Gastroenterology (ACG) is pleased to present testimony to your Subcommitee concerning S.1551, the bill that would provide for equitable administrative appeals and judical review under Medicare for Part A & B claims.

The Health Care Delivery system has changed dramatically over the past several years. Within the system, our senior citizens have certain rights that are designed to protect them from unscrupulous providers, fraudulent Medicare contractors, and others in the medical "profession" who would possibly take advantage of them. The entire Medicare system has historically been the number one advocate of top health care delivery for our nation's older people. Ocassionally we need to remind ourselves of this -- and when we do, it is important to ask if the Medicare system is doing everything possible to maintain adequate medical care and fair treatment for the nation's aged individuals. In some cases the answer is no, an example is in the Medicare claims appeals process.

Recently, the Administration, without notice, eliminated the right of Medicare beneficiaries to be represented in their appeal by their physician or hospital when appealing Part A Medicare claim denials. For years Medicare beneficiaries and providers had the right to work together in filing an appeal. Swift action is necessary to restore a senior citizen's option to be represented by a medical professional in their appeal. This is a major factor in ensuring a fair review.

Further, the increasing use of doctor offices and other outpatient settings to perform more costly procedures necessitates an effort to update the manner in which a Medicare beneficiary appeals Part B claims denials. Medicare Part B appeals are now heard by hearing officers often employed by an insurance carrier. Because much more is at stake for the beneficiary it would be wise to allow a hearing to be conducted by an administrative law judge for a Part B Claim greater than five hundred dollars ($500.00). For disputes of more than one thousand dollars ($1,000.00) it would be appropriate to have judicial review available if the beneficiary is not satisfied with the results of the administrative law judge review.

It is the understanding of the American College of Gastroenterology that these positive measures are contained in the House Budget Reconciliation package. We urge you, Mr. Chairman, to see that these provisions, which are identical to your bill, are retained in the budget reconciliation package when it goes to conference. In light of the reality that the budget package may become bogged down because of unreasonable across the board cuts, we encourage you to move this legislation through the Finance Committee and to final enactment by the Congress.

Thank you for the opportunity to present our views.

ahca
American Health Care Association 1200 15th Street, NW, Washington, DC 20005 (202) 833-2050

STATEMENT ON

FAIR MEDICARE APPEALS ACT, S. 1551

TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
U.S. SENATE

NOVEMBER 1, 1985

Mr. Chairman and Members of the Subcommittee:

The American Health Care Association strongly supports the Fair Medicare Appeals Act introduced by Chairman Durenberger, with co-sponsors including Senators Heinz and Chafee. AHCA is the nation's largest organization of long term care providers.

First, this bill gives important statutory protection to the right of Medicare beneficiaries to select freely their most competent representation for the claims appeals process. To secure their rightful Medicare coverage, beneficiaries could be represented by their service provider. They may not do so under recently changed regulations.

Beneficiaries had this right of choice until the Health Care Financing Administration prohibited representation by the provider in April, 1984, without opportunity even for public comment. This is an ill-founded regulatory barrier to a beneficiary's ability to appeal coverage denials made by fiscal intermediaries. The contention that this change was to eliminate a possible "conflict" which could occur between a beneficiary's interest and that of their representative-provider is fallacious. This fallacy is clear by the beneficiary support this bill and the lack of evidence from HCFA that consumers have actually been improperly represented. Beneficiaries and providers have a complementary, not conflicting, interest.

Many Medicare beneficiaries are unequipped to battle the cumbersome, intimidating bureaucratic process. Because of their physical and mental condition, beneficiaries often are either unable to represent themselves or require assistance in understanding and appealing denials. If no family member is available, they may be forced to forgo appeals, since the relatively small recovery and limited availability of public interest legal assistance often means that no other assistance is available.

A non-profit organization of proprietary and non-proprietary long term health care facilities dedicated to improving health care of the convalescent and chronically ill of all ages. An equal opportunity employer.

Reauthorizing beneficiaries to be represented by providers would greatly enhance the beneficiary's basic right of appeal and increase the likelihood of their receiving the benefits for which they have contributed and are entitled. The "fine print" of Medicare coverage is unfortunately something of which providers are all too familiar.

HCFA's prohibition is comparable to other recent, ill-conceived regulatory changes designed to cut budgets by bureaucratic blockades; actions which Congress has repeatedly overturned.

Second, this bill properly extends the right to appeal coverage denials to Part B services. Medicare beneficiaries with long term care needs often utilize Part B services, such as physical therapy and durable medical equipment. The present lack of an avenue of appeal places an unfair and excessive financial burden upon beneficiaries when Part B carriers retroactively deny coverage.

We recognize that this Committee did not have the benefit of this hearing before its budget reconciliation decisions were made. However, these provisions were included, after a hearing, in the House-passed Medicare and Medicaid budget reconciliation bill (Section 157 of H.R. 3128). To expedite enactment of these beneficiary protections, we strongly urge the Senate to accept these provisions in conference committee. We applaud the Committee's commitment to improving beneficicary access to Medicare long term care services in its budget reconciliation package. Your efforts could be enhanced by accepting the House provisions since one of the present obstacles to Medicare access is providers' reluctance to participate in the program because of the uncertainty of payment.

In addition, the quality and timeliness of the appeals process could be greatly improved by organizing a corp of Medicare administrative law judges within HCFA. Presently, most appeals are decided by Social Security ALJs. Because of the increasing complexity of the Medicare program and the volume of Medicare appeals all involved would be well served by instituting a division of labor, a specialization. We urge the Committee to direct the Secretary of Health and Human Services to develop a HCFA office of hearings and appeals.

We appreciate the opportunity to present our recommendations and urge quick enactment of S. 1551.

American Healthcare Institute

Affiliated with American Healthcare Systems

Merlin K. DuVal, M.D.
President

STATEMENT FOR THE RECORD

BY

AMERICAN HEALTHCARE INSTITUTE

BEFORE

SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH
HEARINGS ON S.1551

1919 Pennsylvania Avenue • Suite 703 • Washington, D.C. 20006 • 202 293-2840

This statement is submitted by the American Healthcare Institute on behalf of the 35 Shareholders in American Healthcare Systems to draw the Committee's attention to the need for review and reform of the Medicare appeals process. Since the enactment of the Medicare program in 1965, the opportunities and procedures for appeals have not been significantly altered. At the same time, there have been extensive changes in the coverage and payment policies of the program. We believe there are now compelling reasons for revision of the appeals process as recommended in S. 1551.

BACKGROUND ON MEDICARE APPEAL RIGHTS

Under present law, Medicare beneficiaries may request a reconsideration of an initial denial decision by a Medicare fiscal intermediary or carrier involving issues of entitlement to benefits or the amount of benefits. If, on reconsideration, the initial denial is affirmed, procedures for appealing the matter beyond the contractor level are different under Part A and Part B of the program.

Under Section 1869 of the Social Security Act, individuals may request a reconsideration of decisions made by a Medicare contractor (i.e. a fiscal intermediary or carrier) concerning:

1. whether the individual is entitled to benefits under Part A or Part B; and

2. the amount payable under Part A.

With respect to issues concerning entitlement to benefits, appeals are first considered by the Social Security Administration (SSA). Initial decisions by SSA may be appealed to an administrative law judge, then to the Appeals Council of SSA and, ultimately, to a federal court for judicial review of the Secretary's final decision.

If the controversy involves the amount of benefits payable under Part A, the fiscal intermediary makes the initial determination with reconsideration conducted by the Health Care Financing Administration (HCFA). If the dollar amount in controversy is greater than $100, the beneficiary may request a hearing on HCFA's decision by an administrative law judge, and a further hearing by the Appeals Council. If the amount in controversy exceeds $1,000, the beneficiary has the right to judicial review of the Secretary's final decision.

For appeals involving the amount of benefits under Part B, the initial determination of a carrier may be reconsidered by the carrier; and, if the amount in controversy exceeds $100, the beneficiary may request a hearing by a hearing officer provided by the carrier. There isn o further administrative appeal of these Part B controversies and no right to judicial review.

In addition, there are separate appeals procedures that apply to decisions made by Peer Review Organization (PROs) pursuant to contracts with HCFA (Section 1155). Under these provisions beneficiaries are entitled to reconsideration of PRO denials and administrative and judicial review of PRO decisions subject to minimum dollar amounts of the decisions in dispute. It should also be noted that institutional providers may also appeal certain reimbursement decisions to the Provider Reimbursement Review Board (PRRB) under separate statutory provisions set forth at Section 1878 of the Social Security Act.

RECENT DEVELOPMENTS AFFECTING MEDICARE APPEALS

As this Committee knows well, a number of important developments have occurred in recent years affecting opportunities for Medicare beneficiaries and providers to obtain reviews of program coverage and payment decisions. First, in the 1983 amendments to the Social Security Act, Congress directed the implementation of a prospective payment system (PPS) for inpatient hospital services. Under PPS, there is no administrative or judicial review of the determination of "budget neutrality" or of the designation of diagnosis-related groups and their associated weighting factors.

In practice, these limitations under PPS preclude virtually all provider payment appeals except those related to reimbursement of services not presently covered by PPS and to disputes involving the allowability of costs for purposes of establishing a hospital's base year under PPS.

The second development whichhas affected appeal opportunities under the Medicare program has been the recent, unilateral decision by HCFA to prohibit beneficiaries from naming the provider of services (physician, supplier, or institution) as their representative for purposes of pursuing an appeal under Section 1869. In taking such a significant step, HCFA provided no public notice, convened no public hearings, and made no attempt to engage in the formal rulemaking process under which such policy matters should be handled. The announcement of this new restriction in the appeals procedures was communicated by letter to Medicare contractors last spring.

Finally, it is apparent that there is a dramatically increasing volume of Medicare services being provided outside the institutional setting. Coverage of these ambulatory services is provided under Part B of Medicare. The historic disparity in the appeals process between Part A and Part B is more troublesome in this era of rapidly growing ambulatory services. Appeals of Part B coverage decisions, as noted earlier, are limited to a reconsideration and a hearing by the carrier only if the amount in controversy exceeds $100. There is no further administrative or judicial recourse.

S. 1551, THE FAIR MEDICARE APPEALS ACT

The Fair Medicare Appeals Act, would make several needed modifications in the statutory provisions at Section 1869. First, the bill would authorize appeal of determinations of the amount of benefits under Part B to an administrative law judge if the amount in controversy as at least $500. Second, it would authorize judicial review of such determinations when the amount in controversy is at least $1,000. Finally, the bill would provide a statutory basis for beneficiaries to designate the physician or provider which furnished the services involved as their representative in any administrative hearing or judicial review that may be pursued.

We believe that this legislation is necessary and, in fact, overdue. For too long, individuals enrolled in the Part B program have suffered the inequity of an appeals process that terminates with the final decision of the Medicare carrier. In contrast, under Part A, Medicare beneficiaries and providers have enjoyed more access to due process for those payment and coverage disputes that arise in the administration of the program. Importantly, decisions of Medicare fiscal intermediaries under Part A are reviewable by independent administrative law judges, by an Appeals Countil, and, ultimately, by the federal courts. We see no reason why disputes of a similar magnitude (both financially and from a policy standpoint) should not be afforded equal due process.

Moreover, we believe these new statutory provisions can contribute to more consistent and effective administration of the Part B program by the Medicare carriers. The emergence of a new body of precedents from administrative and judicial proceedings will be important in bringing more uniformity and equity to the administration of Part B.

We think it is also necessary to make these changes in view of the growing financial obligations placed on beneficiaries through their cost-sharing obligations for a larger volume of

Part B services. In short, with more and more Medicare services being provided under Part B, the financial consequences of carrier decisions on beneficiaries are potentially more burdensome. Adequate and prompt appeals mechanisms for beneficiaries in these circumstances are essential.

Finally, we beleive that the ability of physicians and providers to participate and assist with the appeals process at the request of the beneficiary is vital and reflects common sense. The Medicare program, particularly its administrative and policymaking apparatus, is a complicated area not well understood by the public at large. Moreover, the issues that arise in connection with a denial of coverage or payment amount by a Medicare contractor can be extremely complex and the provider that is responsible for the service or claim in dispute can offer valuable aid and insight to the judgment of these matters. To deny beneficiaries this assistance (as proposed by HCFA) represents a substantial impediment to our goal of assuring fair treatment to all program participants.

Mr. Chairman, we believe your legislation would establish parity between the appeals process for Part A and Part B, and assure that program beneficiaries have the access and support to pursue their rights fully and fairly. We strongly support S. 1551 and urge the Committee to report this measure favorably and promptly.

Thank you for this opportunity to share our views and recommendations on this bill. We are anxious to work with you and the Committee to promote its enactment.

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

submitted for the hearing record to the
SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

November 1, 1985
Hearing on the "Fair Medicare Appeals Act"

The American Physical Therapy Association represents over thirty-seven thousand physical therapists, physical therapist assistants, and physical therapy students. Physical therapists work in a variety of settings serving Medicare patients: hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, and independent physical therapy practices. We submit this testimony for the record on behalf of S. 1551, the "Fair Medicare Appeals Act of 1985."

We are pleased that Senators Durenberger, Heinz, and Chafee have introduced S. 1551, the "Fair Medicare Appeals Act of 1985." This bill offers a legislative remedy for the unfair situation Medicare beneficiaries and providers currently find themselves in when they wish to appeal a decision to deny payment for services rendered or received.

First, S. 1551 would permit provider representation of beneficiaries at appeals hearings. Many beneficiaries are intimidated by the complex Medicare system and appeals process and feel unable to present an appeal of their own. Nor do many have family members who are able to help them in this way, or the resources to hire a lawyer to represent them. Consequently, prior to the January 1984 directive from the Health Care Financing Administration (HCFA) barring such representation in Part A cases, beneficiaries often requested that providers serve as their representative in an appeals hearing. As professionals directly involved in the provision of services, providers are knowledgeable about Medicare regulations in general, in addition to being familiar with the specifics of the case being appealed and as a result are well-placed to represent the beneficiaries concerned.

Allowing provider representation of beneficiaries does not create a conflict of interest, as HCFA maintains. While a successful appeal does allow the provider to maintain a favorable waiver of liability status, more importantly, a successful appeal allows the patient to continue receiving necessary services. It should be noted that, even though HCFA's policy to disallow provider representation dealt specifically with Part A services, providers seeking to represent Part B beneficiaries have subsequently been discouraged as well. Specifically, in response to an American Physical Therapy Association inquiry, HCFA's Office of Coverage Policy stated that, "in our opinion, the rationale for the policy precluding a provider from representing a Part A beneficiary applies equally to a provider seeking to represent a Part B beneficiary." The question was referred to HCFA's legal department in November of 1984; and our office has not yet received a definitive interpretation of the question of Part B supplier representation.

We are pleased that S. 1551 mandates a hearing before an administrative law judge for Part B appeals totalling $500 or more, and judicial review for amounts over $1000. The present "fair hearing" procedures are neither impartial nor fair. A representative of the carrier is appointed to review claims initially denied by that same carrier.

This procedure was more acceptable when Part B claims were for relatively small amounts of money. Over the last few years, however, and especially since the inception of the Prospective Payment System, Part B dollar amounts have risen substantially. A record number of Part B claims were appealed during the past year. Of the approximately 20,000 appeals which were filed, about one-half of these were for amounts of $500 or more.

It is particularly important that the appeals procedure proposed in the bill be instituted at this time. The volume and complexity of Part B claims will continue to increase under the Prospective Payment System, as Medicare patients are released from the hospital sooner, and consequently in need of more outpatient follow-up care. This has placed Part B carriers under enormous pressure to curb the rapid growth of this part of the Medicare system. It is vital, then, that beneficiaries have the right to an impartial review of their Part B Medicare claims.

Finally, we take this opportunity to bring to the Committee's attention a serious situation which is not addressed by S. 1551. That is the use of a statistical sampling procedure by HCFA to project a dollar figure for denials of Medicare claims. The Department has taken the percentage of overpayments found from a very small sample of claims in several home health agencies and rehabilitation agencies, and projected this percentage to be the percentage of overpayments for all of these particular providers' claims in the cost year. Because the Department's demand for repayment is based on a projection rather than on specific cases, the appeals process can not be used.

The result of this intimidating technique has been to drive several providers to the point of bankruptcy. The ultimate result, of course, is that beneficiaries are denied needed services.

We are pleased to note that the language of S. 1551 has been included in the House version of the Medicare reconciliation legislation, and respectfully request that the Senate conferees adopt this language as well.

STATEMENT
OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
SENATE FINANCE COMMITTEE, SUBCOMMITTEE ON HEALTH
FOR THE RECORD OF THE
NOVEMBER 1, 1985
HEARING ON MEDICARE APPEALS PROVISIONS

The American Society of Internal Medicine (ASIM), a national medical society consisting of physicians recognized as specialists in internal medicine, supports the "Fair Medicare Appeals Act of 1985" (S. 1551). The bill would make much needed modifications in the current process for appealing benefit determinations under Part B of the Medicare program.

Specifically, S. 1551 would provide that, where the amount of controversy was over $500, the beneficiary could appeal the carrier's determination to an administrative law judge (ALJ). In cases where the amount of controversy was over $1,000, the beneficiary would be entitled to judicial review of the ALJ's decision. In addition, two or more claims could be aggregated for the purposes of review if they involved the delivery of similar or related services to the same individual or involved common issues of law and fact arising from services furnished to two or more individuals. Finally, beneficiaries could choose to be represented by "providers" which furnished the services in appeals procedures.

Unlike Part A, beneficiaries have been and continue to be precluded by the Medicare Act from appealing Part B claim determinations beyond the carrier level. The rationale given for foreclosing administrative and judicial review in such cases was that the amounts in question under Part B were expected to be relatively small compared to those under Part A and that allowing access to the courts would overload them with claims for cases involving insubstantial amounts. Much has changed, however, in the 20 years that have passed since the adoption of this policy. The advent of the prospective payment system for hospitals has created incentives for a greater proportion of care to Medicare beneficiaries to be given in the outpatient setting, thereby coming under Part B. Also, the use of sophisticated, new medical techniques in the outpatient setting further exposes beneficiaries to out-of-pocket liability. The increasing complexity of rules for coverage and benefit amount determination under Part B results in a greater opportunity for misunderstandings and disagreements in interpretations of the applicable rules. ASIM believes that a concern for due process demands that beneficiaries as well as physicians have the right to appeal the carrier hearing determination. This concern for fairness and justice must outweigh the administrative interest in limiting the scope of the appeals process.

The need for authorizing appeals of carrier determinations under Part B is confirmed by a June 28, 1985, report of the General Accounting Office (GAO) on the Medicare Part B beneficiary appeals process (GAO/HRD-85-79). GAO found that there is a "high risk of underpayment in beneficiary-submitted claims with large reasonable charge reductions and that carrier safeguards were ineffective in preventing these underpayments." Recent experiences of ASIM members further bear out this finding. To address this, the Society has recently embarked on a systematic, nationwide effort to document performance of Part B carriers with regard to claims processing. ASIM believes that its

Carrier Accountability Monitoring Project (CAMP) will benefit the Medicare program by providing a clearer picture of the actual strengths and weaknesses of the process. A description of the program is attached to this statement. This type of program, although important, can only identify claims processing and reimbursement problems experienced by patients and physicians. It cannot provide them and their patients with the access to judicial relief that in many instances may be needed.

ASIM feels the provision of S. 1551 allowing provider representation of the beneficiary in the claims appeal process is an important one. Physicians are the best and often the only parties in possession of information needed to explain and justify the need for medical services and the charges made for them. This is especially true since funding levels for carrier activities to educate beneficiaries about the claims determination process are insufficient in this era of budgetary constraints.

In conclusion, allowing administrative and judicial review of Part B claim determinations by Medicare carriers will greatly improve the ability of patients to obtain the benefits to which they are legally entitled. ASIM would be pleased to assist the Committee further in its consideration of this legislative proposal.

T-2122

ASSOCIATION OF SLEEP DISORDERS CENTERS

STATEMENT BY

PHILIP R. WESTBROOK, M.D.

Vice-President, Association of Sleep Disorders Centers

and

Director, Sleep Disorders Center
Mayo Clinic
Rochester, Minnesota

before the

Senate Finance Committee
Subcommittee on Health

concerning

Medicare Part B Coverage

on

December 6, 1985

Mr. Chairman, I am Dr. Philip R. Westbrook, a physician who directs the Sleep Disorders Center at Mayo Clinic in Rochester, Minnesota. I am pleased to represent the Association of Sleep Disorders Centers and Clinical Sleep Society which comprises over 1000 doctors and 120 facilities throughout the country that diagnose and treat patients who have difficulty falling asleep, staying asleep or remaining awake.

I am honored to discuss Medicare Part B coverage. In general, I advise that revisions be made to reflect the medical realities of disease in the elderly as we presently understand them. As you well-know, our population's age distribution is shifting towards the elderly. Each year, a greater proportion of our medical practices are comprised of Medicare patients. The elderly have more diseases as a group and are individually more likely to have multiple diseases. New technologies can diagnose and treat those elderly at risk for medical catastrophes before death or disability claim their tolls in quality of life and Medicare expenditures. The control of high blood pressure is just one example.

My specific message to the Committee is that many of these diseases, particularly those of the heart and lungs, change for the worse on a nightly basis during sleep. In people over 65 years of age, most disease-related deaths and disease-related medical catastrophes (such as heart attack and stroke) occur during the hours of sleep. Any new reimbursement program for physicians such as prospective plans based on Diagnostic Related

Groups, must recognize the 24-hour nature of disease and accordingly provide for responsible care. It is medically wrong, for example, to treat, with antihypertensive drugs and stimulants, an elderly man with hypertension who falls asleep at the wheel of his car and snores every night. Such a treatment may lead to stroke, heart attack or a multi-vehicle accident. Yet, current Medicare guidelines and payment policies force the health care system into such short-sighted treatments because patients cannot afford the necessary tests for sleep related abnormalities.

Like my center at the Mayo Clinic, most sleep disorders centers are run by specialists in internal medicine who have studied for additional accreditation in diagnosing and treating sleep disorders. The emphasis on internal medicine and specialized training stems from the fact that most frequent sleep disorders are associated with life-threatening cardio-pulmonary problems during the night, such as sleep apnea, asthma, heart disease and chronic obstructive pulmonary disease.

Our ability to differentially diagnose patients with sleep complaints has progressed rapidly in the past ten years. We now have well-accepted guidelines and rationales for treating sleep disorders with surgery, mechanical devices, medication or some combination of these approaches. There is broad consensus as to the life-threatening nature of cardio-pulmonary abnormalities in sleep and risks of falling asleep while driving a vehicle or operating dangerous machinery. Furthermore, recent studies indicate that over 90% of the patients evaluated by sleep disorders centers are significantly improved by recommended treatments. The great impediment that we face as clinicians is that the elderly are reluctant to seek out our expertise because Medicare pays so little for the costs associated with testing. This fact has recently been supported by reports from members of the Association of Sleep Disorders Centers. I will describe two types of life-threatening, yet treatable, medical conditions. For both, current Medicare policy effectively prevents treatment due to inadequate reimbursement.

Inappropriate use and overuse of sleeping pills is particularly common in elderly, Medicare patients. Many patients began such treatments years before modern knowledge was available. Most of the prescriptions for sleeping pills are written for this category of patients. Research indicates that cardio-pulmonary disorders, also common in the elderly, are exacerbated by sleep and account for the disproportionate number of medical catastrophes that occur during the night. Sleeping pills enhance the depression of respiration and cardiac function that normally accompanies sleep. Inappropriate use of sleeping pills in the elderly may also contribute to confusion and locomotor problems and thus potentiate accidents and falls. This vicious cycle can now be broken with rational approaches to problems of sleep in the elderly.

Second is the major problem surrounding people who cannot stay awake to function. Such patients often take prescribed stimulants, to help them stay awake while driving a vehicle or during activities that require sustained alertness. The United States Senate in report #99-152 accompanying the fiscal year 1986 Appropriations Bill for the Department of Transportation has recognized the potential impact these disorders have on highway safety. Stimulants, such as amphetamines, are proper treatment for only 10% of the people who have prescriptions for stimulants. For example, the most common cause of an inability to stay awake in the day is the disorder of sleep apnea which is characterized by symptoms of loud irregular snoring and high blood pressure. Stimulants are medically inappropriate for such patients. Now we know how to correctly diagnose conditions of excessive somnolence and provide appropriate treatment for the millions of Americans with these symptoms.

We ask that this Committee carefully review reimbursement practices for Medicare patients with sleep disorders as delineated in Paragraph 3132.77 of Medicare Part B coverage. The language in this section has not been changed for over ten years. Yet the field has made many important advances. As experts in the field, we suggest that revisions be made that are in line with present knowledge and standards of practice. Detailed comments on specifics have been provided along with a transcript of my remarks. Thank you.

ASDC Position
Paper #3
(12/15/84)

PROPOSED GUIDELINES FOR MEDICARE

.77 Sleep disorders centers - Sleep disorders centers are facilities in which certain illnesses are diagnosed through patient evaluation which includes objective measurement of sleep. These centers provide several diagnostic or therapeutic services which are covered under Medicare. Generally, sleep disorders centers are affiliated with a hospital or medical center and coverage for diagnostic services would, under some circumstances, be covered under different provisions of the law than therapeutic services.

A. Criteria for Coverage of Diagnostic Services - All reasonable and necessary diagnostic tests performed for sleep-related symptoms are covered when required to document the conditions listed in B below and when the following criteria are met:

1. The center is either affiliated with a hospital or is under the direction and control of physicians.

2. Patients are referred to the sleep disorders center by their primary care physician or evaluation by the centers' physician indicates the need for diagnostic testing. In either case, the center must maintain records of physician orders and test results.

3. The need for diagnostic testing is confirmed by medical evidence, e.g., physician examination and laboratory tests performed by the physicians in the sleep disorders center.

4. The reliability and accuracy of the diagnostic methodology is well established. Polysomnographic recording is a necessary and reliable diagnostic testing method for most sleep-related disorders.

   Diagnostic testing that is duplicative of previous testing done by the primary care physician is not covered if previous results are still pertinent.

B. Medical Conditions for Which This Testing is Covered - Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the conditions listed below. Most of the patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and leave the following day after testing is completed. The overnight stay would be considered an integral part of these tests.

1. Narcolepsy: This term refers to a syndrome characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness and sometimes disturbed nocturnal sleep. Diagnostic testing is covered if the patient has inappropriate sleep episodes or attacks (e.g., while reading, in the middle of conversation), periods of amnesia, or continuing sleepiness which significantly interferes with occupational or educational pursuits or with other necessary everyday activities. The sleep disorders center records must document that the symptoms are severe enough to interfere with the patient's well-being and health in order for Medicare benefits to be provided for diagnostic testing. One nocturnal polysomnographic recording and a maximum of five daytime "nap" recordings are generally necessary and sufficient for diagnosis and may be covered.

2. Sleep Apnea Syndromes and Sleep-Related Alveolar Hypoventilation: these are disorders which involve cessation of breathing or marked impairment of breathing during sleep. All of these breathing disorders during sleep can be severe and potentially life-threatening because of profound hypoxemia, associated cardiac arrhythmias and other cardiopulmonary sequelae, as well as potentially disabling daytime somnolence. Although there are a variety of sleep-related breathing disorders, most conditions can be categorized as one of the following:

   a. Upper Airway Apnea. Patients with this condition stop breathing because of sleep-related occlusion of the upper airway. Profound daytime somnolence is common because of the sleep disturbance resulting from breathing difficulty. This condition can be associated with other disorders (e.g., retro or micrognathia, marked obesity) or may exist alone. Surgical treatment of associated disorders directed at the upper airway occlusion itself (e.g., tracheostomy) is frequently necessary and is also covered.

   b. Central Apnea. Patients with this disorder stop breathing during sleep because of a central nervous system dysfunction which occurs only during sleep and results in an absence of respiratory effort. Nocturnal awakenings and somnolence and other daytime sequelae are common. Potentially lethal cardiovascular consequences can be associated with central apnea.

   c. Sleep-Related Alveolar Hypoventilation. This condition is characterized by sleep-related hypoxemia which results from a worsening of breathing in patients with a variety of pulmonary (e.g., chronic obstructive lung disease), cardiac (congestive heart failure) and other (e.g., obesity) medical disorders. Additionally, primary alveolar hypoventilation (Ondine's curse) manifests most dramatically during sleep. Severe hypoxemia, hypercapnia and behavioral and cardiopulmonary sequelae may result from sleep-related hypoventilation and sleep disruption associated with any of these conditions.

   Diagnosis generally requires one night of polysomnography which is covered. A maximum of five daytime "nap" tests may also be covered if a physician judges this necessary for accurate diagnosis of potentially disabling symptoms.

3. Sleep-Related Seizures. All-night clinical electroencephalographic (EEG) recordings are conducted in sleep disorders centers for the purpose of diagnosing seizure disorders which are manifest only during sleep. Abnormal behaviors during sleep (e.g., muscle rigidity, sleepwalking, apparent nightmares) are occasionally related to seizure discharges. One all-night EEG is covered provided that routine EEG results are not diagnostic of the condition underlying nighttime symptoms.

4. Persistent Insomnia. Polysomnographic recordings are covered for patients who have a complaint of severe and persistent (four or more nights per week for greater than three months duration) insomnia which has not responded to alterations in sleep habits or which returns following cessation of short-term therapy (e.g., sedative-hypnotic administration). In many instances the complaint of insomnia is associated with underlying medical conditions (e.g., restless legs syndrome, sleep apnea, periodic leg movements during

sleep, alpha-delta sleep, sleep-related gastroesophageal reflux) which are typically occult during wakefulness. Additionally, in infrequent cases polysomnography can be useful for diagnosis of insomnia related to affective disorders, sleep/wake schedule (circadian rhythm) abnormalities and a variety of other medical conditions. Up to two polysomnographic procedures are covered for the diagnosis of severe, persistent insomnia.

5. Impotence. Diagnostic nocturnal penile tumescence testing may be covered, under limited circumstances, to determine if erectile impotence in men is organic. Although impotence is not a sleep disorder, the nature of the testing requires that it be performed during sleep with simultaneous polysomnographic monitoring of sleep/wake state. The tests ordinarily would be covered only where necessary to confirm the diagnosis and appropriate treatment to be given whether surgical, medical or psychotherapeutic. The contractor's medical staff should review questionable cases to ensure that the tests are reasonable and necessary. (See section 35-24 of the Coverage Issues Appendix (27.201 in the "NEW DEVELOPMENTS" division) for policy coverage of diagnosis and treatment of impotence.

C. Coverage of Therapeutic Services - Sleep disorders centers may also render therapeutic as well as diagnostic services. Although only the diagnostic services indicated above are covered under Medicare, therapeutic services may by covered provided they are standard and accepted services and are reasonable and necessary for the patient. This may include polysomnographic assessment of treatment:

1. In a hospital outpatient setting.

2. In a free-standing medical facility.

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Beechwood Nursing Home
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Betty Scott-Boom
Senate Committee on Finance
Washington, D.C. 20510

This statement is submitted regarding the Oct. 28 hearing on Medicare Appeals Provisions.

As regulation currently stands a provider of Part A and B Medicare services can only have an audit appeal hearing if the payment or reimbursement amount is $10,000 or greater.

As the committee is aware, gathering nursing home participation in the Medicare program is a serious problem around the country. Much of this provider reluctance is due to the paperwork involved. However, the appeals provisions do not help either.

The $10,000 happens to be a very high floor for the average nursing home around the country. This amount represents 30% of the average billings of facilities that do participate. As the program regulations and auditors get tighter on reimbursable items, interpretations by program personnel should be subject to review without needing such a large threshold. Smaller dollar amounts are just as important, especially when they come out of your own pocket and can continue to do so year after year once a precedent is set.

Not lowering this limit thus leads to unwarranted burdens on the provider and will ultimately further reduce participation in the Medicare program. Even if procedures must be changed to more efficiently handle these appeals, please give this matter serious consideration.

Brook Chambery

Brook Chambery
Controller

For the Record
Appeals Hearing -
November 1, 19

October 25, 1985

SUBCOMMITTEE ON HEALTH
FINANCE COMMITTEE
UNITED STATES SENATE

Statement of NATIONAL MEDICAL CARE, INC. In Support of the Fair Medicare Appeals Act of 1985 (S.1551)

National Medical Care, Inc. ("NMC") respectfully submits this statement in support of the proposed Fair Medicare Appeals Act of 1985 (S.1551) (the "Appeals Act"), hearings on which have been scheduled before your Subcommittee on November 1 October 28, 1985. NMC request that this Statement be entered into the record of the October 28 hearing.

NMC is a privately-held corporation with its principal offices located in Waltham, Massachusetts which owns and operates or manages 186 kidney dialysis centers in 30 states in the United States. NMC is also a manufacturer and supplier of medical products, including life-sustaining dialysis, respiratory and infusion therapy supplies for home patients. NMC participates as a Medicare Part B supplier of medical services and products, serving over 18,000 Medicare beneficiaries.

NMC strongly supports passage of the Appeals Act in order to correct and update the present Medicare Act[1] which presently does not permit Medicare Part B beneficiaries or their assignees to have their claims adjudicated by a party other than the insurance carrier acting as agent for Medicare. In 1982 the Supreme Court held in a case (U.S. v. Erika[2]) that involved claims of a subsidiary of NMC amounting in the aggregate to $1,454,513 that Congressional intent, as expressed in the original 1965 Medicare Act and its 1972 amendment, as well as the legislative history concerning these statutes, barred NMC from having these claims ever adjudicated and that the decision of the insurance carrier was final. Prior to reaching the Supreme Court, the Court of Claims *en banc* decided unanimously that the insurance carrier had erred and that NMC was entitled to relief on the merits[3]. The result of several years of litigation, then, was that, although NMC's claims had been handled improperly by the insurance carrier, no relief could be granted under the Medicare Act.

Using *U.S.*v. *Erika* as precedent many federal courts in the past three years have refused to hear any cause of action that might result in the correction of a Part B claim, even where the issue in dispute is one of *policy* that relates across the board to all claims for similar medical services or supplies[4]. Thus, general Part B policy issues, for example, whether Part B covers a particular procedure or test, are not justiciable and are left in the control of the carriers, applying guidelines established by the Department of Health and Human Services. Thus "protected" from any judicial check, the Department and its carrier-agents have the power to restrict and reduce Part B coverage, and in NMC's own experience, have already begun to do so.

Under Part A of the Medicare Act[5] a claim of the magnitude and importance of the Erika claim from a beneficiary or his "provider" (e.g., a hospital, extended care facility or home health agency) would be adjudicable, first to the Provider Reimbursement Review Board, then to the Secretary of Health and Human Services, and finally to the federal courts. The proposed Appeals Act would correct this anomalous and irrational distinction between claims arising under Part A and Part B of the Medicare Act.

NMC submits that the Appeals Act is necessary and desirable for the following reasons.

The most compelling and irrefutable reason is one of fairness and equity. The Appeals Act does not alter any benefit payable under Medicare, but simply establishes a mechanism whereby larger claims (those over $500) can be reviewed by an independent hearing officer or a federal judge. The Appeals Act adopts the view expressed in Part A that the insurance carrier (or intermediary) should not be the sole judge of the propriety of its own claims processing, but that the beneficiaries and their assignee-suppliers are entitled, as a matter of fairness, to an outside, independent review. Without such review, even simple arithmetic mistakes are not correctible, and the lack of oversight eliminates diligence on the part of the carriers. NMC believes that Congress should entrust the final disposition of Medicare claims to the administrative or judicial branch of the government, not to private insurance companies.

In addition, Medicare Part B coverage ("Supplementary Medical Insurance"), unlike Part A, is separately purchased and contracted for by Medicare beneficiaries. The current premium for Part B coverage is $15.50 per month. Thus, Part B benefits are not "entitlements" but contractually-defined rights for which the patients have paid consideration. Since the insurance carriers that administer Part B for Medicare have incentives to reduce claims paid, these carriers are in fact the worst possible referees of disputes between themselves and the policy beneficiaries. No one would suggest that the interpretation of a private insurance contract between an insurance company and an individual be left to the sole discretion of the insurance company. That precept should be just as compelling for a government sponsored insurance contract.

Moreover, the Appeals Act is necessary and desirable, because it responds to changes in Medicare and the U.S. health care system that have occurred since Medicare's enactment, 20 years ago. Presently under Medicare regulations[6] the insurance carrier on its own motion can suspend payments to a supplier-assignee, if the carrier determines that overpayments have been made to the supplier in the past. Thus, the carrier may refuse to pay current claims, even where these claims are properly reimburseable, if it has unilaterally found errors in prior claims, and Medicare permits no appeal from such suspensions. This is a very powerful weapon in the hands of the insurance carrier. The remedy is appropriate if, in fact, the carrier is correct, but there should be some mechanism to permit the supplier-assignee to have the carrier's determination reviewed by an independent tribunal. Also, in the past several years there has been a considerable shift away from institutional care of the sort covered by Part A towards home care and outpatient care which are generally covered by Part B. This shift in Medicare (and other health care insurance) dollars away from the more expensive in-patient setting is one that has been encouraged by the government and the private insurance system. As a result, the volume of Part B claims and the average amount of these Part B claims have increased. The original Congressional rationale supporting the exclusion of administrative or judicial review of Part B claims, namely, that Part B claims would be small and therefore not important enough to occupy the time of federal administrators and judges, is no longer valid. The 1965 Senate Committee report stated, in part:

> "... the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A."[7]

Medical technology has advanced since 1965, making it more convenient and less expensive to perform all sorts of sophisticated diagnostic and therapeutic procedures in the out-patient setting. Claims for these procedures and services are often submitted under Part B and are not for insignificant amounts, as witnessed by NMC's own experience cited above.

The rationale of excluding from review a large volume of Part B claims for small amounts remains valid and is continued in the proposed Appeals Act. The Appeals Act excludes from any independent review all claims of $500 or less, leaving these to the carrier's sole discretion. Claims over $500 would be reviewed by an administrative law judge appointed by the Department of Health and Human Services and his decision regarding claims over $1,000 could be appealed to the federal courts. In addition, the cost to the beneficiary or the assignee of prosecuting appeals will also serve as a barrier to a flood of litigation. Given these costs, it's unlikely that an appeal would be filed with the federal district court unless the claim was considerably more than the $1,000 statutory hurdle.

NMC believes the proposed Appeals Act should be adopted for the reasons cited above. It's difficult to imagine any credible arguments in opposition to its enactment. The Appeals Act will improve the Medicare system by further encouraging the shift from costly in-patient care under Part A to more efficiently-delivered out-patient care under Part B and by treating Part B suppliers (physicians, out-patient clinics and home supply companies, for example) as equal partners in the Medicare health care delivery system. The Appeals Act is long overdue and NMC urges your Subcommittee to recommend its immediate enactment.

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REFERENCES

[1] 42 U.S.C. §1395j *et seq.*

[2] 456 U.S. 201 (1982)

[3] *Erika, Inc.* v. *U.S.*, 634 F. 2d 580 (Ct. Cl. 1980)

[4] *Herzog* v. *Secretary*, 686 F. 2d 1154 (6th Cir. 1982)
Hargrett v. *U.S.*, 3 CL. CT. 655 (1983)
Starnes v. *Schweiker*, 748 F. 2d 217 (4th Cir. 1984)

[5] 42 U.S.C. §1395 c *et seq.*

[6] 42 C.F.R. §§405.370 - 405.373

[7] S. Rep. No. 404, 89th Cong., 1st Sess., 55.

Statement of

BESS M. BREWER

MEDICARE ADVOCACY PROJECT, INC.

Hearing Date:	October 28, 1985
Subject of Hearing:	Medicare Appeal Provisions
Statement Prepared:	November 8, 1985

STATEMENT

The following statement has been prepared to assist the Senate Committee on Finance with their review of Medicare Appeal Provisions. Of special concern is the inadequacy of the Medicare Part B appeals process.

I am an attorney with the Medicare Advocacy Project (MAP). Map is a legal services organization which provides education, counseling and representation, with regard to Medicare problems, to Los Angeles County residents. Part of my work entails representation of Medicare beneficiaries at Part A and Part B hearings. The following comments are based on actual experience.

By way of background, I have provided a brief description of the appeals process under Part A and Part B of Medicare. The Medicare claims and appeals process varies significantly depending on whether a claim arises under Part A or Part B.

The first step in processing any Medicare claim for payment is the submission of a claim by the beneficiary or provider to the appropriate private insurance company acting as fiscal intermediary (Part A claims), or carrier (Part B claims).

The insurance company then pays, reduces or denies in full the claim in its 'initial determination'. A claimant who is dissatisfied with this determination then has the opportunity for a paper review (Part B) or reconsideration (Part A). The review/reconsideration is made by the insurance company which made the initial determination. After this in-house review/reconsideration, a claimant who is still dissatisfied may request a hearing if the amount in controversy is one hundred dollars ($100.00) or more. At this stage the type of hearing and subsequent procedures begin to differ depending on whether the claim arose under Part A or Part B.

Under Part A, the hearing is held before an Administrative Law Judge of the Social Security Administration, followed by a review by the Social Security Appeals Council if the claimant so requests. Untimately, if the amount in controversy is one thousand dollars ($1,000.00) or more, a claimant is entitled to judicial review in Federal Court.

In contrast, the Part B hearing is before a hearing officer appointed and paid for by the Part B insurance carrier. Furthermore, the decision of the hearing officer is final without possibility of further review.

From the above description, it is clear that Medicare beneficiaries have far greater rights under Part A of Medicare. Part B rights are extremely limited. Equally troublesome is the appearance (if not actual) of conflict of interest raised by having the Part B carrier perform the initial determination, review, and hearing.

Although Part B hearing officers are ostensibly independent of the carrier, the semblance of independence is destroyed when one realizes that the hearing officer is paid by the carrier and is usually a former employee of the carrier, thus bringing carrier orientation to the hearing. The effect on beneficiaries is harmful in two ways. Medicare Part B benefits are more apt to be denied, and beneficiary outrage and sense of frustration with the Medicare program is intensified.

In order to fully appreciate the inadequacy of the Part B appeals process, I would like to share a recent experience with you.

A 78 year old woman called MAP and requested assistance with her Part B appeal. Represenatation of this elderly woman was severly hampered by the inadequacy of the Part B appeals process. Frustration with the process began with the review determination notice provided by the carrier. The carrier affirmed the initial denial of coverage for services. Although trained in law I was unable to ascertain from the notice the exact reason(s) for denial. The review determination notice was comprised of stock phrases providing the reader with a smorgasbord of possible reasons for denial. Preparation for the hearing was therefore extremely difficult since I was forced to guess at the reasons for denial.

Prior to the hearing I requested additional information and clarification regarding the exact reason(s) for denial. Unfortunately I never received a response much less the requested information.

The actual hearing proved to be even more frustrating. The hearing officer, although ostensibly unbiased, was a former carrier employee. At the hearing she stated that she was unfamiliar with the exact rules and regulations governing the particular issues in controversy. She was also unable to articulate the exact reasons for denial. However, her lack of knowledge was of no concern because the actual "research" on the case was going to take place after the hearing. She indicated that her decision would be based on carrier guidelines and the consultant's opinion. She made these statements despite her recital at the outset of the hearing of a preprinted statement which read, "The hearing officer's decision will be based on testimony and evidence given at the hearing."

When we requested a copy of the guidelines and law she was going to rely upon to make her decision, she refused to provide the information stating that if we wanted it, we would have to go through the Freedom of Information Act.

Six months after the hearing I received a copy of her decision affirming the initial determination. (Attached please find a copy of the actual hearing decision marked Exhibit 1).

It does not require a constitutional law scholar to realize that beneficiaries are being denied basic procedural due process and fair hearing rights under current Part B appeal provisions.

Senator David Durenberger of Minnesota has introduced S.1551 which would remedy the most serious procedural deficiencies in the Medicare Program. It contains in part, the following provisions:

1. Part B hearings would be changed to conform to the hearing provisions already provided for Part A claims in that the hearing would be conducted by an independent administrative law judge if the amount in controversy is over five hundred dollars ($500.00). This would help insure an impartial Part B hearing Also, unlike Part B hearing officers, administrative law judges are not bound by HCFA's policy manuals and so are free to disregard them when they believe they conflict with the Medicare statue, and;
2. Judicial review would be available for Part B appeals as is the case with Part A appeals.

Unlike proposals to expand Medicare benefits, these procedural reforms would not cost the government much money. The return, would be a more equitable system and increased beneficiary satisfaction.

I am hopeful that once the inadequacies of the Medicare Part B appeals process are brought to the attention of the Committee, they will lend their voice and support to Senator Durenderger's bill.

Respectfully submitted,

Bess M. Brewer

Bess M. Brewer
Attorney

PROCEEDING BEFORE
TRANSAMERICA OCCIDENTAL LIFE
INSURANCE COMPANY (Carrier)

In the Matter of:	)	HIC #
	)	082-22-1602-B
Beneficiary	)	Decision of Hearing Officer on Request for Fair Hearing

This proceeding was initiated by Bess Brewer, director of a Medicare Advocacy Project (MAP) on behalf of Ola Vorster, in accordance with provisions of Title XVIII of the Social Security Act which grant the right of a fair hearing to an individual who is dissatisfied with the amount of benefits allowed by the Carrier on a claim under Part B of Medicare. The hearing was conducted at the office of the Carrier, Transamerica Occidental Life Insurance Company, on March 27, 1985. Although Mrs. Vorster was present at the hearing, she was represented by Ms. Brewer. Also present were co-counsel Sally Wilson, and Michael Parks, an attorney ~~you~~ who wished to observe the proceeding. Jeanne B. Moore presided as Hearing Officer.

THE ISSUES

Mrs. Vorster received services from Evan Evans, D.C., totalling $612.25. On the unassigned claim, the Carrier denied any allowance. The issue before the Hearing Officer is whether the denial by the Carrier was reasonable and proper, in view of the facts and applicable law.

EXHIBIT 1

THE FACTS

The services Mrs. Vorster received from Dr. Evans between January 5 and November 29, 1983 consisted of chiropractic manual manipulations of the spine and diet supplements. The total charges were $612.25 and the Carrier denied any allowance.

Following the initial determination of the Carrier, Mrs. Vorster requested a review. The Carrier upheld its original position at the review level and Ms. Brewer subsequently asked for a hearing. After several postponements, requested by Ms. Brewer, the hearing was held on March 27, 1985.

After the Hearing Officer's opening statement, Ms. Brewer wanted to provide a brief history of Medicare coverage of Mrs. Vorster's chiropractic claims. Since 1978 Mrs. Vorster has been receiving chiropractic manual manipulations of the spine by Dr. Evans. Until 1981, Medicare paid for the services. Then, in 1981 and 1982, the claims were initially denied, then upon review, the claims were paid. In 1983, Mrs. Vorster received 17 chiropractic treatments and they were totally denied. Mrs. Vorster requested a review but this time the Carrier still denied the claims and Mrs. Vorster requested a hearing. Ms. Brewer stated for the record that preparation for the hearing was made a lot more difficult due to the inadequacies of the review determination notices that were sent out by the Carrier. In the first one Mrs. Vorster received,

dated May 30, 1984, basically gave a general statement of Medicare coverage of chiropractic services. In other words, it explained that only manual manipulations of the spine were covered and explained the need for an X-ray for documentation. At no point, however, did the reviewer apply these generalized statements to Mrs. Vorster's particular situation. The letter seemed to contain only stock phrases and after reading the notice you were no closer to finding out why the services were denied.
Mrs. Vorster then received a second notice dated February 13, which was an improvement over the first, but not perfect. This notice again explained that only manual manipulations were covered and also pointed out the need of documentation in the form of an X-ray. In addition, the second notice brought up a totally different basis for denial in that it stated that there must be reason to believe that more treatments would help Mrs. Vorster and the reviewer did not feel this was so in Mrs. Vorster's situation. Mrs. Vorster stated that, after reading both notices, the exact reason for denial was still unclear. Although Ms. Brewer is a "Medicare Advocate" she does not seem to be very well versed in the laws, regulations and guidelines of Medicare. It should be obvious that the review notices sent to Mrs. Vorster by the Carrier would not have been sent if they were not applicable to her case.

Initially, Ms. Brewer said she'd like to clarify a few points regarding the standards of coverage of chiropractic services. It is their understanding that Medicare coverage is limited to manual manipulations of the spine for the purpose of correcting a subluxation of the spine and the subluxation must be documented by X-rays taken at a time that's reasonably approximate to the initiation of the course of treatment. One of the review notices stated that the X-ray must be taken within 12 months of the start of treatment. There was some discussion between the Hearing Officer and Ms. Brewer regarding the Carrier's parameters for periods of chiropractic treatment.

Ms. Brewer gave the Hearing Officer a letter from Dr. Evans describing Mrs. Vorster's condition. According to the letter, Mrs. Vorster "Shows considerable osteoarthritis changes in her spine and a degree of osteoporosis. Mrs. Vorster was born with an anatomical short left leg. This condition was exacerbated by 2 accidents which resulted in 2 serious surgeries of this leg. Mrs. Vorster's left leg is approximately one inch shorter than her right. This results in a misalignment of her spine. Mrs. Vorster also remits and exacerbates in and out of low back and mid-thoracic pain. After her accidents, Mrs. Vorster began a course of treatment with me. Her chiropractic course of treatment, based on orthopedic and neurological examinations, includes manual manipulations of the spine. Even though the shortness of her left leg results in continual wear and tear on her physical structure and spine. The goal of the course of treatment, of which manual manipulation of the spine is an integral part, is to keep Mrs. Vorster as structurely stable and as pain free as possible. The treatments help to alleviate Mrs. Vorstar's considerable pain and restore flexibility to her spine and allow Mrs. Vorster a greater range of motion and movement. To this end her course of treatment has been 80-90% successful. Based on her progress thus far, it is reasonable to conclude that this course of treatment will keep her pain in check and retard further deterioration. Without these treatments, Mrs. Vorster would be in considerable pain and her range of motion would become more and more constricted...." The letter was dated March 23, 1985 and was signed by Evan Evans, D.C.

The Hearing Officer asked Mrs. Brewer when Mrs. Vorster last had an X-ray. Ms. Brewer stated that X-ray's were taken in 1980 when the course of treatment directed to the spine and lower back was initiated. In 1983, as part of the continuing course of treatment, Mrs. Vorster received 17 treatments. Ms. Brewer referred to Dr. Evans's letter in which he states the goal of the treatments was to alleviate Mrs. Vorster's pain, restore flexibility, bring her back into alignment, and that the treatments were 80-90% effective.

Mrs. Brewer directed questions to Mrs. Vorster. In answer to the question of what happens if she doesn't see Dr. Evans for a period of time, Mrs. Vorster said that her whole structure is such that her function is greatly limited. In defining "structure" Mrs. Vorster explained that her gait gets "out of wack" and her back gets out of alignment. She stumbles and feels like she's walking like a drunkard. She sometimes almost falls down. She gets rigid and has to think first before she tries to even bend and has great pain getting up again when she's gardening, which is something she very much likes to do.

Ms. Wilson asked for copies of the specific guidelines that are the basis of the decision since they've had difficulty in figuring out exactly what the rules are with respect to chiropractic services and the rules with respect to X-rays. Rules they are familiar with speak in terms of an X-ray at the beginning of a course of treatment but it seems that perhaps there are more than one set of rules for X-rays during the course of treatment. In addition, there seems to be rules regulating the number of treatments a person may receive. The Hearing Officer advised that the applicable "rules" would be a part of the decision but Ms. Wilson still wanted a xerox copy of the provisions. The Hearing Officer suggested Ms. Wilson request such information from the Carrier's Certification Department under the Freedom of Information Act. Mrs. Wilson asked the Hearing Officer to delay the decision for 30 days to give council the chance to study the rules so they would know how to direct their argument within the specific language of the rules. The Hearing Officer agreed to delay the decision upon written request, Although it was the opinion of the Hearing Officer that this information should have been researched and/or requested prior to the hearing.

Ms. Wilson again questioned the rules as far as the X-ray is concerned. As mentioned before, Ms. Wilson testified, the course of treatment for the back and lower region of the spine was initiated in 1980 and the documented X-rays are dated 1980 and are available if anyone wants to review them. The X-rays were taken within the 12 months of the start of treatment. The 1983 treatment which is at issue is a continuation of the treatment initiated in 1980. Mrs. Vorster's condition is chronic and another "incident" did not occur. It has all been a part of the original course of treatment which started in 1980.

The "observer," Mr. Parks, asked if the Hearing Officer's decision would quote only the portion of the rules which the Hearing Officer feels are applicable to this case or if the "whole" rules regarding chiropractic coverage would be stated. Mr. Parks pointed out that the Hearing Officer had stated that the case had already taken too much time to accept further evidence and that it would be impossible to know what evidence to submit that would be relevant within the guidelines since they had never seen the guidelines. Ms. Wilson wanted to know if they had to wait for the decision to learn the guidelines and also, if they would have the opportunity to review the Consultant's comments prior to the decision. The Hearing Officer reminded all present that the hearing was an administrative proceeding not a court of civil law and a 30 day extension had already been agreed upon. It appeared that the council wanted to review, step by step, any information or comments used by the Hearing Officer to make a decision, prior to the actual and/or final decision so that rebuttal could be prepared to specifically address each eventuality. Such practice would be unacceptable in an administrative proceeding although it might be acceptable in a civil court.

The Hearing Officer again explained the conditions under which a reopening could be requested. From the testimony, it was evident that council has already had access to, at least, some of the relevant material. What seemed to be questionable is the Carrier's guidelines and the consultant's comments. The Hearing Officer advised that she would render the determination, not the consultant. If a reopening is requested, the Hearing Officer will also make the determination as to whether or not a reopening is to be granted. Council was concerned that a request for reopening might not fit the requirement for reopening. If they could have access to a consultant's or physician's report prior to the decision it might throw a completely different light on what's being discussed at the actual hearing. If they had all the information developed by the Hearing Officer, they would be better able to present evidence that would clarify their position based on the Consultant's comments and could alleviate the necessity of requesting a reopening. The Hearing Officer stated that she would not consult with them after contacting the consultant unless the consultant requested additional information. It was the Hearing Officer's opinion that counsel wanted to know before hand what the decision would be so they could present a rebuttal if the determination is unfavorable. The Hearing Officer advised that she had no intention of contacting council or Mrs. Vorster unless more information was needed.

The rest of the hearing was more or less redundant and the Hearing Officer feels it is not necessary to continue to repeat the same discussions again in this document. Council did ask to review Mrs. Vorster's file, which was then done with the Hearing Officer's approval. It was the feeling of the Hearing Officer that council, more or less, wanted to put the Hearing

Officer on the "witness stand" to extract a decision during the course of the hearing or, that the Hearing Officer assist council in preparing their case. This, of course, would not be within the scope of the Hearing Officer.

Approximately 30 days after the hearing, Ms. Brewster sent the Hearing Officer the attached document which is identified as Exhibit #1. It is obvious, from this document, council has thoroughly reviewed regulations regarding chiropractic coverage.

THE LAW

Chapter III of the Medicare Carrier's Manual, issued by the Department of Health and Human Services, Health Care Financing Administration states, in part, in Section 3300; "Carriers have the authority and responsibility to determine, in a given case, whether a claim is for covered service and deny claims for non-covered or excluded items of service. In addition, Carriers are to assist in the application of safeguards against unneccesary utilization of services furnished eligible individuals. In carrying out it's responsibilities, the Carrier must take the necessary steps to reconcile any inconsistencies between diagnosis and treatment during bill review. Issues involving apparent inconsistencies between diagnosis and treatment and other questions relating to the reasonableness of items for services rendered by a physician should be reviewed by the Carrier's medical staff. Bill review techniques developed as a result of the Carrier's experience and may be used or adopted for operations applicable to this program."

Section 1861 (r)(5) of Title XVIII of the Social Security Act limits coverage for services by a chiropractor to ". . . only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by x-ray to exist)."

Coverage and limitations to coverage are contained in Chapter II of the Medicare Carriers Manual, issued by the Department of Health and Human Services, Health Care Financing Administration. Section 2251.5 deals with treatment parameters for chiropractic claims. It states in part, "Carriers should develop parameters under which an extension in the course of treatment could be supported based on special documentation of need and under which coverage will be finally terminated for lack of reasonable expectation that continuation of treatment could be beneficial." The Carrier's parameters have been established at a maximum of thirty-six treatments for a specific diagnosis, with the x-ray date being reasonably proximate to the treatments. "Reasonably proximate" is described as within three months for an acute condition or within twelve months for a chronic condition. The patient must have an improvement potential, and this may be considered exhausted after thirty-six treatments.

SUMMARY AND ANALYSIS OF THE EVIDENCE

Mrs. Vorster received chiropractic manual manipulations totalling $612.25. The Carrier denied any allowance.

At the hearing, representatives for Mrs. Vorster felt that the Carrier's reasons for denial of the services were unclear. It appears that the Carrier had initially denied allowance because there was not evidence of a recent X-ray. Later, Mrs. Vorster was informed by the Carrier that there was not reason to believe that further treatments would improve Mrs. Vorster's condition. There was a lengthy discussion regarding these issues plus the fact that the representatives felt that they were not sufficiently informed as to the "rules" regarding these issues. It was the opinion of the Hearing Officer that the attorneys expected the Hearing Officer to provide all the information necessary for them to uphold their request for reconsideration. This information is a matter of public record and, as attorneys, Mrs. Vorster's representatives could and should have researched it.

Following the hearing, Ms. Brewer sent the Hearing Officer a memorandum (identified in this document as Exhibit I) which emphasized 4 points which she felt were applicable to this case. The Hearing Officer will now enumerate and comment on each of these points.

I. Medicare's chiropractic coverage extends to chronic subluxation of spine.

The Hearing Officer agrees with this statement but feels a more appropriate description would be, "Chiropractic coverage is limited to manual manipulation for chronic subluxation of the spine."

II. Verifying X-ray of subluxation must be taken no more than 12 months prior to initiation of course of treatment. In the case of chronic subluxation an older X-ray may be accepted.

The Hearing Officer also agrees with this statement. However, it should be noted that for a course of treatment that extends over a period of years, interim X-rays should be taken periodically to document the medical necessity of continued treatment.

III. Medicare's chiropractic coverage is justified if chiropractic treatment either affects improvement or rests or retards deterioration.

The Hearing Officer also agrees with this statement. It should be pointed out, however, that Medicare coverage for this type treatment cannot be prolonged and/or allowed indefinitely.

IV. Judgements about the reasonableness of chiropractic treatment should be based on chiropractic principles and Carriers should make use of chiropractic consultation.

> All of the material and evidence pertinent to Mrs. Vorster's care was referred by the Hearing Officer to a chiropractic consultant. His comments were as follows; "Because of the one inch deficiency of this lady's left leg, her low back will never be completely relieved. Had this deficiency been present in early life her body would have adopted. The manipulations rendered appear to exceed the suggested guideline of 36 treatments. This lady will probably never become "well", however, the relief of pain would be significant. There is no indication of any attempt to lift the left side by building up the shoe. The lift may relieve, although some people do respond negatively. The Carrier's guidelines have always supported an X-ray within 12 months even though the chiropractic consultant might occasionally have stretched a point where only a month may be involved."

As a result of her research, Ms. Brewer has made some salient points to support her contention that benefits should be allowed for Mrs. Vorster's

1983 treatments. There are some facets however, that appear not to have been considered and/or mentioned in Ms. Brewer's memorandum. For instance, some of the applicable quotes were highlighted on the exerpt from the Commerce Clearing House which was included with the memorandum. The last paragraph on page 1052 (which was not highlighted) is very pertinent to this case and is included in this document in the third paragraph under "The Law."

Dr. Evans stated in his letter of March 23, 1985 that Mrs. Vorster was born with an anatomical short left leg. Ms. Brewer wrote in her memorandum that; "Because of a double fracture of her leg suffered in 1975, Ola Vorster's left leg is considerably shorter than her right leg...." Mrs. Vorster has been receiving chiropractic treatments from Dr. Evans since 1976. Medicare allowed benefits through 1982.

It should be noted that Medicare coverage for chiropractic services is very limited. Medicare law requires that covered services must be reasonable and necessary for an individual's condition. In addition, the Carrier is required by HCFA mandate to apply safeguards against unnecessary utilization of services furnished eligible individuals. Based on the Carrier's prior claims experience, guidelines are developed by the Carrier's Medical Policy Committee and must be approved by HCFA before implementation. When an individual's restorative potential is insignificant in relation to the extent or duration of chiropractic treatments required to achieve such potential, the treatments would not be considered reasonable and necessary for the individual's condition. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. Such expectation may not always prove to be valid, and the realization that restoration will not occur can, and should be, reached in a reasonable and generally predictable period of time.

According to Dr. Evans, Mrs. Vorster's treatments had been 80 to 90% successful. It is the opinion of the chiropractic consultant (and the Hearing Officer agrees) however that she will never be completely well. Continuation of treatment for Mrs. Vorster's chronic condition could only be considered palliative and/or maintenance care.

The Medicare program was designed primarily for individuals over 65 years of age and it is assumed that, in the over 65 age bracket, many individuals suffer from chronic and, in many instances, irreversible conditions. However, the program was not intended to provide coverage for palliative and/or maintenance care, but rather to provide protection in the event of catastrophic illness or injury.

FINDING OF FACTS

1. Mrs. Vorster received services totalling $612.25.
2. The Carrier denied any allowance.
3. The services Mrs. Vorster received consisted of

chiropractic manual manipulations of the spine.

4. Mrs. Vorster's treatments have been 80 to 90% successful.
5. Mrs. Vorster does not demonstrate restorative potential to warrant extension of treatment beyond what has already been considered.
6. Allowance is not warranted.

DECISION

The denial by the Carrier was reasonable and proper, based on the facts and applicable law. The determination of the Carrier, therefore, is hereby affirmed and upheld.

DATED: October 8, 1985

Hearing Officer

TO:

Bess Brewer
2639 S. La Cienega Blvd.
Los Angeles, CA 90034

cc: Transamerica Life Companies

NAMES
NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

STATEMENT

of the

NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

before the

SENATE FINANCE COMMITTEE

on

MEDICARE APPEALS

November 1, 1985

618 SOUTH ALFRED STREET ALEXANDRIA, VIRGINIA 22314 (703) 836-6263

Statement of NAMES before the Sentate Finance Committee on Medicare Appeals

November 1, 1985

Thank you Mr. Chairman for allowing the National Association of Medical Equipment Suppliers (NAMES) to present its views regarding beneficiary and provider appeals under Parts A and B of the Medicare program, and S.1551, the Fair Medicare Appeals Act of 1985.

NAMES, with a membership of over 1,600, is the largest trade association representing home care medical equipment suppliers throughout the country. Our members serve over 2 million patients who are able to avoid institutionalization because of the availability of medical equipment ranging from walkers and wheelchairs to oxygen, ventilators and high-tech infusion therapy. Home care equipment suppliers provide not only the equipment but also the services that are essential to ensure proper functioning and use of the equipment in the home. Most NAMES members serve Medicare beneficiaries and a high percentage accept assignment of the beneficiary's claims.

NAMES supports S.1551 and believes the time has come to place beneficiaries under Part B on the same footing as those under Part A. Part B beneficiaries are the only American citizens without the right to contest denials of coverage or improper payment of health care benefits. Our testimony focuses on the Medicare Part B program, how the services under Part B have changed since 1965, how the limited system of review currently in effect is working and what determinations are not subject to any independent third-party review and analysis either in court or a fair hearing.

Original System

Judicial review was originally denied Part B beneficiaries because the Part B program was viewed as generating numerous claims for small amounts of money. Under these circumstances, Congress did not want the resources of the Federal Court system to be unduly taxed by overloading the courts with "quite minor matters", to quote one of the sponsors of the bill, Senator Bennett (R-Utah). Since that observation was made, Part B has become a very different program, and many of these matters can no longer be considered minor. The implementation of the DRG system for hospitals under Part A, and increasing awareness that lower cost care and treatment of patients may be provided under Part B outside of a hospital or skilled nursing facility is a case in point. In addition, both carriers and HCFA have developed restrictive policies and procedures which are applicable to all beneficiaries and which are by any definition quite significant given the fact that they affect all beneficiaries either on a state-wide or regional basis, or throughout the country.

Policies Without Review

The Committee may not be aware that for a substantial portion of the Part B program even an administrative hearing is unavailable. In addition there is no requirement that major reimbursement policies be published in the Federal Register. This unfortunate lack of any independent, third-party review results from HCFA regulations narrowly defining the responsibility and authority of a hearing officer. Section 405.860 of the Medicare regulations provides that the hearing officer is required to comply not only with all provisions of the Medicare Act and formal regulations, but also with all policy statements, instructions and other guidelines issued by HCFA. If, for example, HCFA determined that home chemotherapy for cancer patients was no longer a covered service and issued a one page instruction with no opportunity for public comment, the only recourse available to beneficiaries would be passage of legislation by this Committee.

The Committee and staff might want to take a look at the Medicare Part B carrier's manual, number HIM 14-3. This is the third of three substantial documents that are prepared by HCFA and issued to the carriers. It weighs at least five pounds, contains approximately 3,000 pages and outlines HCFA's procedures and responsibilities for computing reimbursement levels, and determining coverage issues. It is frightening, but true, that not one item contained in this manual is subject to review or question by a hearing officer, or a court. The manual is not even subject to publication in the Federal Register. In short, this voluminous document has the same legal effect on a beneficiary that a law passed by this Committee has has with two important exceptions: 1) laws are passed only after searching public debate; 2) laws of Congress are subject to judicial review and can be ruled unconstitutional.

In reducing Medicare expenditures, HCFA has taken full advantage of this lack of public scrutiny and implemented dozens of very significant initiatives in the Medicare Part B program which are not subject to review. This Committee is certainly aware of the rent/purchase and oxygen coverage guidelines as well as guidelines on parental and enteral nutrition. These and dozens of other initatives may be issued with complete impunity; The courts refer to this authority as "unbridled discretion."

Current Law

Currently, the Medicare Act explicitly accords court review to disputes regarding entitlement to benefits under both Parts A and Part B; disputes regarding the amount of benefits, are subject to review only under Part A. Specifically, § 1869 of the Act provides:

> Section 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b) (1) Any individual dissatisfied with any determination under subsection (a) as to--
>
> (A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title, or section 1818 or
>
> (C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205 (b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205 (g).

(Section 1869 is codified at 42 U.S.C. §1395ff(b)). (Emphasis supplied.)

In short, the Act, while permitting court review of the amount of benefit determinations under Part A, does not permit court review of disputes relating to the amount of Part B benefits.

In addition to § 1869, the Medicare Act provides the following regarding court jurisdiction:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such a hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal or governmental agency except as herein provided. No action against the United States, the Secretary, or any office or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

(Section 205(h) of the Social Security Act (42 U.S.C. § 405(h), incorporated in the Medicare Act by 42 U.S.C. § 1395ii).

This provision has been interpreted by federal courts to preclude judicial review not only of disputes regarding the amount of Part B benefits but also disputes regarding the administration of Part B and the promulgation of any regulations regarding Part B.

Federal Court Interpretation of the Law

The availability of court review of disputes regarding the the Medicare program has been the subject of much litigation. The most significant cases relevant to Part B of the Act and leading to the current status of the law are discussed below.

In United States v. Erika, 456 U.S. 201 (1982), the Supreme Court held that both the language and the legislative history of 42 U.S.C. § 1395ff evidence an intent by Congress to foreclose judicial review of adverse determinations of benefit amounts made under Part B, Erika, supra, 456 U.S. at 208-209. The court's holding was based on the legislative history of the Medicare Act providing that, because Part B amount determinations are generally smaller than smlar determinations under Part A, individual Part B amount determinations should only be reviewable at the administrative level, not at the judicial level, "in order to avoid overloading the courts with quite minor matters." (118 Cong. Rec. 33992 (1972) (statement of Senator Bennett (R-Utah)).

Significantly, in a case decided the same day as Erika, the Supreme Court in Schweiker v. McClure, 456 U.S. 188 (1982), allowed jurisdiction over a dispute involving the administration of the Medicare Act. The Erika case, therefore, obviously was not intended to foreclose judicial review of all disputes involving the administration of Part B of the program (even if the disputes also relate to the amount of benefits). See National Association of Patients on Hemodialysis and Transplantation v. Heckler, 588 F. Supp. 1108, 1117 (D.D.C. 1984).

Following the Erika and McClure decisions, however, the Supreme Court issued its decision in Heckler v. Ringer, 466 U.S. ___, 104 S.Ct. 2013 (1984). In Ringer, the court held that challenges to the administration of the Medicare program are "inextricably intertwined" with claims for benefits. The Ringer court concluded, therefore, that § 205(h) of the Social Security Act prohibits court jurisdiction over any Medicare dispute except when the Act specifically provides jurisdiction. Even though the Ringer case involved Part A of the Medicare program, the case has been relied upon by several federal courts to deny jurisdiction for disputes involving the administration of Part B of the Act because the courts reasoned that (1) the administrative disputes were "inextricably intertwined" with claims for benefits and (2) claims for Part B benefits are not reviewable under the Medicare Act.

One significant case involving Part B of the Act which denied jurisdiction based on the Ringer decision is Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 728 F.2d 326 (6th Cir. 1984), vacated and remanded for reconsideration in light of Heckler v. Ringer, 104 S.Ct. 2013, remand rescinded and original opinion reaffirmed, No. 81-1202 (6th Cir. Mar. 19, 1985). In Michigan Academy, a group of physicians challenged a regulation involving reimbursement under Part B as being in conflict with the Medicare Act. In its initial decision, the court of appeals held that the district court had jurisdiction to hear the case, stating that: "In the absence of federal question jurisdiction, . . . the Secretary apparently would have unbridled discretion to promulgate any regulation he chose." The court of appeals reinstated the case and distinguished it from Ringer on the basis that challenges under Part B of the Medicare Act are allowable where the challenge is made by a party other than a claimant for benefits. The Supreme Court has granted Certiorari in the Michigan Academy case.

A second significant case involving Part B of the Act in which jurisdiction was denied based on the Ringer decision is

Starnes v. Schweiker, 715 F.2d 134 (4th Cir. 1983), vacated and remanded for reconsideration in light of Heckler v. Ringer, 104 S.Ct. 2013, reversed, No. 82-1543 (4th Cir. Nov. 13, 1984), appeal docketed, No. 84-1309 (U.S. S.Ct., Feb. 8, 1985) Certiorari denied ___ U.S. ____ (April 15, 1985). In Starnes, Medicare beneficiaries challenged a regulation promulgated by HHS involving Part B of Medicare; the beneficiaries argued that the regulation was not promulgated in accordance with the Administrative Procedure Act ("APA") and was in conflict with the Medicare Act. The district court accepted jurisdiction of the case and held that the regulation was not promulgated in accordance with the APA. The court of appeals affirmed the district court's holding. After the Ringer decision was issued, however, the court of appeals, like the court in Michigan Academy, was instructed to reconsider its decision in light of Ringer. Upon reconsideration, the court reversed itself holding that, even though the district court had already determined that the regulation was promulgated in violation of the APA, the courts are without jurisdiction to review a regulation involving Part B of the Act. The court, therefore, was unable to invalidate the regulation. The case was appealed by the Medicare beneficiaries to the United States Supreme Court and Certiorari was denied on April 15, 1985.

A third case involving Part B of the Act in which jurisdiction was denied based on the Ringer decision is Miller v. Heckler, TY-84-453-CA (E.D. Tex. Feb. 5, 1985). In Miller, Medicare beneficiaries and durable medical equipment suppliers located in Texas

alleged that a regulation promulgated by HHS, which resulted in the reclassification of nursing home facilities from "non-skilled" to "skilled," which in turn resulted in the beneficiaries losing Part B benefits, was in conflict with the Medicare Act and was not promulgated in accordance with the APA. Based on the Ringer decision, the court held that it was without jurisdiction to decide whether the regulation should be held invalid. The beneficiaries, therefore, who were without meaningful administrative review, had no avenue to challenge HHS' actions. Significantly, in its opinion, the court termed "unfortunate" Senator Bennett's remarks that the matters were "trivial", but nevertheless stated that plaintiff's remedy lies with Congress, not the courts.

In short, following the Supreme Court's Ringer decision, courts have interpreted the Medicare Act to effectively preclude all judicial review of disputes regarding administration of Part B. At the same time, a number of these decisions indicate they reached this conclusion reluctantly and invited beneficiaries to petition Congress for more equitable treatment.

Administrative Review

The administrative remedies available to Medicare beneficiaries for Part B amount and coverage determinations are set forth in § 1842 of the Act. That provision sets out the contractual duties of carriers employed to administer the Part B program. Specifically, § 1842(b)(3)(C) of the Act provides:

> (3) Each such contract shall provide that the carrier--
> (C) will establish and maintain procedures to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(Section 1842 is codified at 42 U.S.C. § 1395u).

The procedures for administrative review are further defined at 42 C.F.R. § 405.801 *et seq*. The hearings are conducted by an employee of the same carrier who denied the benefits. There is no requirement that the hearing officer be an attorney and discovery is limited to the discretion of the hearing officer. There are no appeals from a hearing officer's determination.

The most egregious problem under the existing hearing process is the hearing officer's inability to overrule or modify a regulation, policy statement, instruction or other guide issued by the Department of Health and Human Services. Thus, unlike the administrative procedures under Part A, beneficiaries and medical equipment suppliers who have been assigned the beneficiary's claims under Part B cannot challenge, *in any forum*, the legality of thousands of decisions made by the Department. These decisions involve both medical coverage and reimbursement determinations. Under Part A policy statements, intermediary letters, manuals, guidelines and other documents developed internally by HCFA without benefit of notice and comment from affected parties are merely advisory and not binding upon the courts. Under Part B, however, as a direct result of the absence of court jurisdiction and the hearing officer's limited authority, policy statements, letters, manuals and the like become virtual law upon issuance.

Fair Hearing Process

In addition to the fact that a substantial number of claims are not subject to a fair hearing, there are problems in the administration of the fair hearing process. First, hearing officers are employees of the carriers who make the determinations. While this has been held to be constitutional, it lends itself to abuse. The fairness and impartiality of the hearing officers and their relationship to the carriers varies from carrier to carrier. Second, since regulations governing the conduct of fair hearings were promulgated by HCFA, there have been no attempts to add due process to the process as the Medicare Part B program has changed. The fair hearing officer does not have the authority to subpoena witnesses. There are no rights to take depositions and no requirements that interrogatories may be served on carriers or HCFA to determine the basis for their decisions. The carriers frequently do not disclose the the basis for their decision or the medical documentation used to deny benefits even at the hearing. Hearing officers have frequent and regular ex parte contact about individual claims or policies with the carrier both before and after the hearing. Hearing officers also may conduct their own investigation and make decisions based on information which was obtained after the hearing which is not in the record and which the beneficiary was incapable of analyzing prior to the decision. Under these circumstances, abuses are to be expected.

In 1982 Pan American Life Insurance Company, the former Medicare Part B carrier for the state of Louisiana, implemented their own coverage guidelines on home oxygen therapy. Part of the policy was published and sent to providers; another important portion was not published. The unpublished portion of the new guideline effectively denied coverage to as many as one half of the beneficiaries using home oxygen therapy who had been previously covered. Knowledge of the criteria was discovered through claims denials and subsequent oral conversations with the carrier which indicated that the criteria used were more stringent, by a substantial degree, than any similar criteria utilized by any other carrier in the United States. Requests for confirmation of the criteria and requests for medical documentation to support the determination were denied under the Freedom of Information Act by the carrier and, upon appeal, by the Deputy Administrator of HCFA. One supplier in the state of Louisiana submitted a number of claims to a fair hearing officer for review on this issue. When they attended the fair hearing, they were informed that the fair hearing officer was aware of the criteria, had discussed them with the carrier, and that the supplier was wasting his time pursuing the issue. This occurred immediately before the hearing. No appeal was available.

This carrier subsequently lost their contract, apparently as a result of inefficiencies in its operation. The new carrier, Blue Cross of Louisiana, changed this policy when it assumed the contract in January, 1985, and made it consistent with policies of other carriers in the surrounding states. However, no retroactive relief was available for the hundreds of beneficiaries harmed by the former carrier's policies.

In a mid-Eastern state there is a case presently before a fair hearing officer. The issue involves reimbursement levels and how they are calculated by the carrier. Under the law the carrier can pay no higher than the prevailing or the customary charge of the supplier or in the case of two products, the lowest charge level.1/

There is an additional criterion in the law which provides that the carrier cannot pay a higher amount than they pay for their own policyholders and subscribers. Somehow, in interpreting this provision the carrier is paying some suppliers as much as 20% less than either their customary or the prevailing charge. In an effort to analyze and question how some suppliers could be reimbursed at substantially different levels than other suppliers for the same product, Freedom of Information Act requests were sent to the carrier and meetings were held. All requests under the Freedom of Information Act were denied and no information was disclosed in the meetings on what method the carrier uses to reach this determination.

1/ HCFA has recently amended the law by regulation to limit increases in reimbursement levels to increase in the consumer price index. (50 Fed. Reg. 40168, October 1, 1985)

The fair hearing officer was provided with interrogatories to submit to the carrier for response, and specific employees of the carrier who work on these policies were asked to testify so that the hearing officer could make a well-informed decision. Answers to the interrogatories were denied by the carrier, and the parties requested to appear at the hearing have refused to attend. In short, this carrier may be reimbursing as the law requires, but we don't know because the information may never be disclosed.

In a Southern state, the carrier's sole hearing officer has taken the position that all reimbursement levels determined by the carrier are not subject to review by a hearing officer because those prices have been individually approved by the regional office. This determination is contrary to hearing officers in other states who have, under some circumstances, reviewed reimbursement levels determined by the carriers. No review of that decision is available.

Other instances of unfair procedures and unfair process can be cited. But the salient point is that HCFA has made no attempt whatsoever to change their procedures to allow for more due process and recognize ongoing changes in the administration of the Part B program.

In summary, Mr. Chairman, NAMES appreciates the opportunity to testify before this Committee and hopes that in the brief time alloted we have shed some light on the abuses which the current lack of judicial review under Part B both permits and encourages. Beneficiaires and suppliers are at this time virtually incapable of protecting their rights -- both programmatic and due process -- when opposed by an administrative process which is answerable to no higher authority in any meaningful way. At present, a beneficiary's only recourse is to petition Congress with complaints or for specific legislation on a case-by-case basis, a clearly impractical course to pursue. Certainly, the better approach is to help beneficiaries help themselves by according them a measure of judicial review, and for this reason NAMES strongly supports S.1551 as a badly needed improvement to the Medicare Part B program.